1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08284

CERTIFICATE OF DEATH

08272

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 2 wks. 4 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Colonial Villa Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Pr. Geo.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville - 6502 - 8th Ave.
d. STREET ADDRESS: ~~12325~~ New Hampshire Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Thomas — Middle: Peter — Last: Adamson

4. DATE OF DEATH: Month: June — Day: 12 — Year: 1967

5. SEX: M

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 12-22-92

9. AGE (In years last birthday): 74 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired- Printer

10b. KIND OF BUSINESS OR INDUSTRY: Bur. of Engr.

11. BIRTHPLACE (County & State, or foreign country): Iowa

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Peter Adamson

14. MOTHER'S MAIDEN NAME: Rose Maux

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 340-03?-402-T

17. INFORMANT: -Mrs. Lorraine A. Miller (above (Daughter), address)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute heart failure
DUE TO (b): CHF
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4341
INTERVAL BETWEEN ONSET AND DEATH: 6-12 mo's

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): CVA

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 5-25, 1967, to 6-12, 1967, that (I) (~~we~~) last saw the deceased alive on 6-6, 1967, and that death occurred at 5:30 M, from causes and on the date stated above.

22a. SIGNATURE: R H Sandstrom M.D.
M.O. ATTENDING PHYS. ☑ MED. DIRECTOR ☑ STAFF PHYS. ☐

22b. DATE SIGNED: 6-12-67

22c. PHYSICIAN'S NAME (Type): R. H. Sandstrom MD

22d. ADDRESS: 7701 Carroll Ave Takoma Park, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6/15/67

23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cem.

23d. LOCATION (City or Town) (County) (State): Colmar Manor, Md.

24. FUNERAL DIRECTOR: Nalley's Funeral Home Inc.
ADDRESS: Mt. Rainier, Maryland

25a. REC'D BY REGISTRAR
DATE: JUN 16 1967

25b. REGISTRAR'S SIGNATURE: J Charles Young

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08285

CERTIFICATE OF DEATH

08274

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (rural)
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 766 Fairview Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Algert — Middle: Daniel — Last: ALEXIS

4. DATE OF DEATH: Month: June — Day: 12 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: Cauc

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 25, 1897

9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S. Navy/Engineering Consultant

10b. KIND OF BUSINESS OR INDUSTRY: U.S. NAVY

11. BIRTHPLACE (County & State, or foreign country): Minersville, Penn.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Alexis

14. MOTHER'S MAIDEN NAME: Helen Kell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) -1954

16. SOCIAL SECURITY NO.: 085-30-7020

17. INFORMANT: Annapolis — Address: Maryland
Mrs. Mabel Glenn Alexis, 766 Fairview Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Embolus
DUE TO: RECCURRANCE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Recurrance and Metastasis of Carcinoma of the
DUE TO: Esophagus
(c):
INTERVAL BETWEEN ONSET AND DEATH

150X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (X) (this hospital) attended the deceased from June 7, 1967, to June 12, 1967, that (I) (we) last saw the deceased alive on June 12 1967, and that death occurred at 810AM, from causes and on the date stated above.

22a. SIGNATURE: Perry Ah-Tye M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 12 June 1967

22c. PHYSICIAN'S NAME (Type): Perry Ah-Tye. M. D.

22d. ADDRESS: Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6-15-67

23c. NAME OF CEMETERY OR CREMATORY: Arlington National

23d. LOCATION (City or Town) (County) (State): Arlington, Virginia

24. FUNERAL DIRECTOR ADDRESS: W. W. Chambers 8655 Georgia Ave. Silver Spring, Maryland

25a. REC'D BY REGISTRAR DATE: JUN 14 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #2c & d Film #0390 6/27/67 pc

08286

08275

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: MONTGOMERY — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OLNEY
   c. LENGTH OF STAY IN 1b: 13 DAYS
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Montgomery County Gen. Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: MONTGOMERY
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OLNEY District Heights, Md.
   d. STREET ADDRESS: BROOKE GROVE FOUNDATION, BROOKE GROVE RD. 7411 Laurel-Bowie St.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN — Middle A. — Last AMOS

4. DATE OF DEATH: Month 6 — Day 9 — Year 19 67

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 10-13-01

9. AGE (In years last birthday): 65 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10b. KIND OF BUSINESS OR INDUSTRY: BUS DRIVER

11. BIRTHPLACE (County & State, or foreign country): VIRGINIA

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOHN C. AMOS

14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 578-10-8400

17. INFORMANT — Address: MEDICAL RECORD DEPT.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Exanguination — INTERVAL BETWEEN ONSET AND DEATH:
   DUE TO (b): Bleeding duodenal ulcer — 2 days
   DUE TO (c): Peptic ulcer, duodenum
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 6, 1964 to June 9, 1967, that (I) (we) last saw the deceased alive on June 8 1967, and that death occurred at 3:40 P.M., from causes and on the date stated above.

22a. SIGNATURE: John R Spencer — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6-9-67

22c. PHYSICIAN'S NAME (Type): JOHN R. SPENCER, M. D.

22d. ADDRESS: 15444 COLUMBIA PIKE, BURTONSVILLE, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6/13/67

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery

23d. LOCATION (City or Town) (County) (State): Suitland Maryland

24. FUNERAL DIRECTOR — ADDRESS: J. Wm. Lees Sons. 300 4th St. NE Wash. DC

25a. RECD BY REGISTRAR DATE: JUN 14 1967

25b. REGISTRAR'S SIGNATURE: Charles Jones

VR A15 (4)
25M 1/67

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08287 08276

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kensington Gardens Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: 9514 Tuckerman st b. COUNTY: Pro Geo County
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Seabrook, Md.
d. STREET ADDRESS: 9514 Tuckerman street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EMMA Middle O. Lost ANDERSON
4. DATE OF DEATH: Month JUNE Day 12, Year 19 67
5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: July 27, 1874
9. AGE (In years last birthday): 92 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (County & State, or foreign country): Sweden
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Esther Mathey Address: Seabrook, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Generalized arteriosclerosis — 30 yrs
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senile Brain Syndrome
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2/1, 1966, to 6/12, 1967, that (I) (we) last saw the deceased alive on 6/12 1967, and that death occurred at 2:? M, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 6/12/67
22c. PHYSICIAN'S NAME (Type): W. F. Kreuzburg
22d. ADDRESS: 7852 16th Ave Hyattsville 20012

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: June 15, 1967
23c. NAME OF CEMETERY OR CREMATORY: Valhalla Cemetery
23d. LOCATION (City or Town) (County) (State): N Hollywood Los Angles Cal.
24. FUNERAL DIRECTOR: ADDRESS: F. Gasch's Sons Hyattsville, Md.
25a. REC'D BY REGISTRAR DATE: JUN 15 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1-12

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08288 — 08277

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove for ban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared with Medical Examiner - 6-9-67

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland — b. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring — c. LENGTH OF STAY IN 1b: D. O. A.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wheaton — 15.1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Holy Cross Hospital	d. STREET ADDRESS: 11500 Amherst Ave. — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
FLORENCE	Caparotti	Anderson	June	3	1967

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	8. DATE OF BIRTH	9. AGE (In yeors last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Fem.	White	Sep	7/7/17	49 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own home	Fort Worth, Texas	U. S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Augustus G. Rintleman	Edna B. Bell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. (If yes give wor or dotes of service)	17. INFORMANT	Address
No	None	220-12-3072	Ralph B. Caparotti - (Son)	2366 Glenmont Circle, Wheaton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction — 3 hrs
DUE TO (b): Arteriosclerotic Heart Disease — 5 yrs
DUE TO (c):

4201

Conditions, if ony, which gave rise to immediate couse (a), stoting the underlying couse last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)			
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	20f (City or town)	(County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from _____, 19__ to June, 19__, that (I) (we) last saw the deceased alive on June 3 1967, and that death occurred at 4:30 PM, from causes and on the date stated above.

22a. SIGNATURE	M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED
George Sharpe		June 3, 1967
22c. PHYSICIAN'S NAME (Type) George Sharpe	22d. ADDRESS 10400 Conn. Ave., Kensington, Md.	

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	June 6, 1967	Parklawn Cemetery	Rockville, Maryland

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Glen Carter Warner E. Pumphrey, Inc.	8434 Georgia Avenue Silver Spring, Md.	DATE JUN 8 1967	Charles Judge

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08289 08278

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

1. PLACE OF DEATH
   a. COUNTY: Montgomery — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (rural)
   c. LENGTH OF STAY IN 1b: 65 days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
   a. STATE: Florida
   b. COUNTY:
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Key West
   d. STREET ADDRESS: 2811 Seidenberg Avenue
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Eugene — Middle: — Last: Anheir

4. DATE OF DEATH: Month: June — Day: 27 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: Cauc.

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 1, 1893

9. AGE (In years last birthday): 74 yrs
   IF UNDER 1 YEAR: Months — Days
   IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U. S. Navy

10b. KIND OF BUSINESS OR INDUSTRY: — — —

11. BIRTHPLACE (County & State, or foreign country): Brooklyn, New York

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service)

16. SOCIAL SECURITY NO: 257 22 9227

17. INFORMANT: Hospital records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): PULMONARY ABSCESS AND PULMONARY THROMBOSIS
   DUE TO
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   (b):
   DUE TO
   (c):
   INTERVAL BETWEEN ONSET AND DEATH

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): MASSIVE GASTRO-INTESTIONAL HEMORRHAGE

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April 23, 19 67, to June 27, 19 67, that (I) (we) last saw the deceased alive on June 27 1967, and that death occurred at 3:40 P.M. from causes and on the date stated above

22a. SIGNATURE: Francis C. Johnson M.D. — ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: June 28, 1967

22c. PHYSICIAN'S NAME (Type): FRANCIS C. JOHNSON M.D.

22d. ADDRESS: Naval Hospital, Bethesda, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6-29-1967

23c. NAME OF CEMETERY OR CREMATORY: Key West City Cemetery

23d. LOCATION (City or Town) (County) (State): Key West Florida

24. FUNERAL DIRECTOR: Jos. Gawler & Sons — ADDRESS: Joseph Gawler Sons, 5130 Wisconsin Ave., N. W. Washington, D. C.

25a. REC'D BY REGISTRAR DATE: JUN 30 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VII A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08290 08279

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): U.S. NAVAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHEVY CHASE
d. STREET ADDRESS: 7605 MEADOW LANE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First CHARLES — Middle — Last ARMSTRONG
4. DATE OF DEATH: Month JUNE — Day 22 — Year 1967
5. SEX: MALE
6. COLOR OR RACE: CAUC
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: SEPT. 25 1886
9. AGE (In years last birthday): 80 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PHYSICIAN MEDICAL DIRECTOR
10b. KIND OF BUSINESS OR INDUSTRY: NIH
11. BIRTHPLACE (County & State or foreign country): ALLIANCE, OHIO
12. CITIZEN OF WHAT COUNTRY?: USA
13. FATHER'S NAME: THEODORE ARMSTRONG
14. MOTHER'S MAIDEN NAME: EMMA BERTOLETTE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Yes CG 1910-1919
16. SOCIAL SECURITY NO: 220 44 5568
17. INFORMANT: MARY E ARMSTRONG — Address: 7605 MEADOW LANE CHEVY CHAS MD.

MED CAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): UREMIA — INTERVAL BETWEEN ONSET AND DEATH: [illegible]
DUE TO
(b): Chronic Pyelonephritis — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from JUNE 20, 1967, to JUNE 22, 1967, that (I) (we) last saw the deceased alive on JUNE 22 1967, and that death occurred at 12:20 PM, from causes and on the date stated above.

22a. SIGNATURE: F. H. O'CONNELL — M.D. ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: JUNE 22 1967
22c. PHYSICIAN'S NAME (Type): F. H. OCONNELL
22d. ADDRESS: US NAVAL HOSPITAL BETHESDA, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 26 Jun 67
23c. NAME OF CEMETERY OR CREMATORY: SENECAVILLE CEMETERY
23d. LOCATION (City or Town) (County) (State): SENECAVILLE, OHIO

24. FUNERAL DIRECTOR: Joseph Gawler's Sons Inc. — ADDRESS: Wash, D.C.
25a. REC'D BY REGISTRAR — DATE: JUN 29 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08291 08280

CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK
c. LENGTH OF STAY IN 1b 79 days
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON SAN. + HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE MARYLAND b COUNTY MONTGOMERY
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING,
d STREET ADDRESS 25 E. WAYNE AVE.
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First MARY Middle Emily Last ARNOLD
4. DATE OF DEATH Month 6 Day 24 Year 1967

5 SEX FE
6 COLOR OR RACE WH
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 3/20/90
9 AGE (In years last birthday) 77 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk XXX
10b KIND OF BUSINESS OR INDUSTRY U.S. Govt. XX
11 BIRTHPLACE (County & State, or foreign country) D.C.
12. CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME WILLIAM ARNOLD
14. MOTHER'S MAIDEN NAME MISSOURI NELSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) None
16. SOCIAL SECURITY NO 217-46-6123
17 INFORMANT William Haughe HOSPITAL RECORDS Address 9909 Woodburne Rd Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Esophagus
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH Several months
150X

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Basal Cell Carcinoma of Face, Cirrhosis
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4-5, 1967, to 6-24, 1967, that (I) (we) last saw the deceased alive on 6-23 1967, and that death occurred at 2:50 PM, from causes and on the date stated above.

22a. SIGNATURE Stuart L. Nelson M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED 6-24-67
22c PHYSICIAN'S NAME (Type) Stuart L. Nelson
22d ADDRESS 831 Univ. E., Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF June 26, 1967
23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery
23d. LOCATION (City or Town) (County) (State) Washington, D C

24. FUNERAL DIRECTOR John B. Thomas Warner E. Pumphrey, Inc.
ADDRESS 8434 Georgia Avenue Silver Spring, Md.
25a. REC'D BY REGISTRAR DATE JUN 28 1967
25b. REGISTRAR'S SIGNATURE Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08292 (08281)

1. PLACE OF DEATH — a. COUNTY: Montgomery — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Darnestown
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): RFD.# 3 Gaithersburg

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) — a. STATE: Maryland — b. COUNTY: Montgomery
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Darnestown
   d. STREET ADDRESS: RFD # 3 Gaithersburg
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First THOMAS — Middle H. — Last ATHEY, Sr.

4. DATE OF DEATH: Month June — Day 10 — Year 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 2/19/95

9. AGE (In years last birthday): 72 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Farmer

11. BIRTHPLACE (County & State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John S. Athey

14. MOTHER'S MAIDEN NAME: Lettie Hall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO: 216-30-4170-A

17. INFORMANT — Address: Willie B. Athey-Item# 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs
DUE TO (b): Coronary Sclerosis — 2-3 yrs
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April, 19 59, to 10 June, 19 67, that (I) (we) last saw the deceased alive on 10 June 19 67, and that death occurred at 5:20 P.M., from causes and on the date stated above.

22a. SIGNATURE: Wm. S. Murphy M.D. — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 6/12/67

22c. PHYSICIAN'S NAME (Type): Wm. S. Murphy

22d. ADDRESS: Rockville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6/13/67

23c. NAME OF CEMETERY OR CREMATORY: Darnestown Church Cem.

23d. LOCATION (City or Town) (County) (State): Darnestown, Md.

24. FUNERAL DIRECTOR — ADDRESS: Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.

25a. REC'D BY REGISTRAR DATE: JUN 15 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and ... event, within 72 hours after death.

VR A15 (4)
20 M 1/66

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08293 08282

1. PLACE OF DEATH
a. COUNTY: Montg omery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Montgomery General Hospital

2. USUAL RESIDENCE (Where deceased lived; If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sandy Spring
d. STREET ADDRESS: Box 33
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Alfreda — Middle: Elaine — Last: Austin

4. DATE OF DEATH: Month: 6 — Day: 11 — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4-26-65

9. AGE (In years last birthday): 2 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Hill

14. MOTHER'S MAIDEN NAME: Frances Austin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Medical Records, Montg. General Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): [illegible] / Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 24 hr.

54.5

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Congenital heart defect — 2 yrs.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John S. Ball M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22. DATE SIGNED: 6/11/67
EXAMINER'S NAME (Type):
Address (Street, city, town, or county):

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 6/15/67
23c. NAME OF CEMETERY OR CREMATORY: ASH MEMORIAL CEMETERY
23d. LOCATION (City, town or county) (State): SANDY SPRING, MONTG., MD.

24. FUNERAL DIRECTOR: Robert L. Snowden — ADDRESS: ROCKVILLE, MD.

25a. REC'D BY REGISTRAR DATE: JUN 15 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
3500 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08294

CERTIFICATE OF DEATH

08288

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Boyds
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Boyds
d. STREET ADDRESS: Route 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edith — Middle: gertrude — Last: Austin

4. DATE OF DEATH: Month: June — Day: 21 — Year: 1967

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: February 18, 1896

9. AGE (In years last birthday): 71 yrs
IF UNDER 1 YEAR: Months: 00 — Days: 3
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired

10b. KIND OF BUSINESS OR INDUSTRY: Postal mistress

11. BIRTHPLACE (County & State, or foreign country): R1, Boyds, Md

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: James H Austin

14. MOTHER'S MAIDEN NAME: Rhoda Ann Stewart

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No

16. SOCIAL SECURITY NO.: 225-60-1023

17. INFORMANT: John H. Austin, Address: Boyds, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): asphyxiation — INTERVAL BETWEEN ONSET AND DEATH: 2 hr
DUE TO (b): Senile debility — 7
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): senile changes

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m., 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan - 1 -, 1963, to June - 21 - 1967, that (I) (we) last saw the deceased alive on June - 18 - 1967, and that death occurred at 6:45 A M, from causes and on the date stated above.

22a. SIGNATURE: William E. Miller, M.D — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6 - 21 - 1967

22c. PHYSICIAN'S NAME (Type): WILLIAM C. MILLER

22d. ADDRESS: 7 Brooke Ave, Gaithersburg, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6-24-67

23c. NAME OF CEMETERY OR CREMATORY: St Marys

23d. LOCATION (City or Town) (County) (State): Barnesville Montg Md

24. FUNERAL DIRECTOR: Ernest E. Gartner Gaothersburg. Md.
ADDRESS: Ernest E. Gartner

25a. REC'D BY REGISTRAR DATE: JUN 26 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08295

CERTIFICATE OF DEATH

08284

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 3 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Montgomery General

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg
d. STREET ADDRESS: 19 Cedar Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Milton	Brook	Austin	6	24	19 67

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS Hours	Min
Male	White	NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	10-9-83	83 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter	Retired	Maryland	U S A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Mahlon Austin	Elizabeth Rawlins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT (Daughter) Address
no	579-10-0278	Mrs. Erances A. Peyton-7807 Brickyard Rd. Potomac, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart
DUE TO (b): Disease with Congestive Heart Failure
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Months (Terminal events)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertrophy of Prostate Gland

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
		1962			

21. **I certify** that (I) (~~this hospital~~) attended the deceased from ~~6-20-67~~ 19__ to 6-24-67, 19__, that (I) (~~no~~) last saw the deceased alive on 6/23 1967, and that death occurred 12:15 AM, from causes and on the date stated above.

22a. SIGNATURE: Jack Schumacher M.D — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 6-24-67
22c. PHYSICIAN'S NAME (Type): Jack Schumacher
22d. ADDRESS: Gaithersburg, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	6/27/67	Mt. Zion	Bethesda, Montgomery, Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Tyson Wheeler Funeral Home	1331 Rockville Pike Rockville, Md.	JUN 27 1967	Charles Judge

1

M

08296

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08285

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN: 18days/13½hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium + Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS (Number and Street or R.F.D. Number): 11807 Indigo Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edward — Middle: John — Last: Bannon
4. DATE OF DEATH: Month: June — Day: 7 — Year: 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Feb. 8, 1893
9. AGE (In years last birthday): 74 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Structural Steel Worker
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Simon Bannon
14. MOTHER'S MAIDEN NAME: Sarah Devers
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: 579-03-5164
17. INFORMANT: Hospital Records — Address: 7600 Carroll Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Renal Debilitation — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): from Carcinoma of the Lung
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
163X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour, a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from May, 1967, to June 7, 1967 that (I) (we) last saw the deceased alive on June 6 1967, and that death occurred at 4A M, from causes and on the date stated above

22a. SIGNATURE: R C Bufalino — M.D — ATTENDING PHYS ☒ — MED DIRECTOR ☐ — STAFF PHYS ☐
22b. DATE SIGNED: June 7, 1967
22c. PHYSICIAN'S NAME (Type): Russell C Bufalino M.D.
22d. ADDRESS: 1429 University Blvd W. Silver Spring Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 10 JUNE 1967
23c. NAME OF CEMETERY OR CREMATORY: GATE of HEAVEN CEMETERY
23d. LOCATION (City or Town) (County) (State): SILVER SPRING MD.
24. FUNERAL DIRECTOR: RINALDI FUNERAL HOME — ADDRESS: 7400 GA. AVE NW
25a. REC'D BY REGISTRAR — DATE: JUN 9 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08297

CERTIFICATE OF DEATH

08286

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver
c LENGTH OF STAY IN 1b: 1 year
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 10901 - Amherst ave.

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d STREET ADDRESS: 10901 - Amherst ave.
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First MAX Middle BARACK Last
4 DATE OF DEATH: June Month 5 Day - 1 Year 1967

5 SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7-17-90
9. AGE (In years last birthday): 76 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrician
10b KIND OF BUSINESS OR INDUSTRY: W.J. Gas Light.
11. BIRTHPLACE (County & State, or foreign country): Austria
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No (WIDOWED)
16 SOCIAL SECURITY NO: Fis. Unk.
17 INFORMANT: Mrs. Sadie Barack Address: 10901 - Amherst ave. S.S. Md.

MEDICAL CERTIFICATION

1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 day
4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic Heart Disease — Unknown
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from Nov. 1965, to 6-1- 1967, that (I) ~~(we)~~ last saw the deceased alive on 6-1 1967, and that death occurred at 11:45 AM, from causes and on the date stated above.

22a. SIGNATURE: Morris Perry M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 6-1-67
22c. PHYSICIAN'S NAME (Type): Morris Perry M.D.
22d. ADDRESS: 11602 Georgia Ave. S.S. Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6-2-67
23c NAME OF CEMETERY OR CREMATORY: Natl. Mem. Park
23d LOCATION (City or Town) (County) (State): Falls Church Virginia
24. FUNERAL DIRECTOR ADDRESS: Goldberg Funeral Home 4217-9th St. N.W. D.C.
25a RECD BY REGISTRAR DATE: JUN 6 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

16

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08298 08287

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: 2 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 3215 University Boulevard West

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
d. STREET ADDRESS: 3215 University Blvd., W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: IDA — Middle: ANTOINETTE — Last: BEALE

4. DATE OF DEATH: Month: JUNE — Day: 7 — Year: 1967

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct 17, 1882

9. AGE (In years last birthday): 84 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired clerk

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Govt.

11. BIRTHPLACE (County & State, or foreign country): Washington, D. C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Francis P. Holmes

14. MOTHER'S MAIDEN NAME: Isabelle Kelser

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Francis G. Read — Address: 2101 ~~Parker~~ Parker Avenue Silver Spring, Maryland

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CONGESTIVE HEART FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 2 WEEKS
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE — 15 YEARS
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from JULY, 1963 to JUNE 7, 1967, that (I) (we) last saw the deceased alive on JUNE 5 1967, and that death occured at 6:32 AM, from the causes and on the date stated above.

22a. SIGNATURE: Robert L. Krichmar M.D.

22b. DATE SIGNED: JUNE 7 1967

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): ROBERT L. KRICHMAR

22d. ADDRESS: 7733 ALASKA AVENUE N.W WASHINGTON D.C 20012

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: June 9, 1967

23c. NAME OF CEMETERY OR CREMATORY: Arlington Nat'l Cemetery

23d. LOCATION (City, town or county) (State): Arlington, Virginia

24 FUNERAL DIRECTOR'S SIGNATURE: Glen Carter — ADDRESS: 8434 Georgia Avenue Silver Spring, Md.
Warner E. Pumphrey, Inc.
E. Glen Carter

25a. REC'D BY REGISTRAR DATE: JUN 12 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08299 08288

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page ... be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete... director, page ... should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7 61

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: month
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sylvan Manor Health Care Center

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Derwood
d. STREET ADDRESS: / /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Minnie — Middle: Bell — Last: BEALL

4. DATE OF DEATH: Month: JUNE — Day: 15 — Year: 1967

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5/19/1900

9. AGE (In years last birthday): 67 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): H. Wife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State, or foreign country): Mont. Co., Md.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William H. Coleman

14. MOTHER'S MAIDEN NAME: Nettie Butt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: -

17. INFORMANT: Rowland O. Beall — Address: 602 Monroe St. Rockville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Hypoproteinemia

DUE TO (b): Chronic Debilitation

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Carcinoma Colon - Origin Undetermined

INTERVAL BETWEEN ONSET AND DEATH: Yrs. / Mos. / Days / Hours / Min.

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June 1, 19 67 to June 15, 19 67, that (I) (we) last saw the deceased alive on June 13, 19 67, and that death occured at 9:25 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Robert T. Thibadeau M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: June 15 67

22c. PHYSICIAN'S NAME (Type): ROBERT T. THIBADEAU

22d. ADDRESS: ROCKVILLE MD. 20852

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6-19-67

23c. NAME OF CEMETERY OR CREMATORY: Rockville Union

23d. LOCATION (City, town or county) (State): Rockville, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Francis H. Barber

ADDRESS: Laytonsville, Md.

25a. REC'D BY REGISTRAR DATE: JUN 20 1967

25b. REGISTRAR'S SIGNATURE: [signature]

1 10

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08300

CERTIFICATE OF DEATH

08289

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH
a. COUNTY: Montgomery County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 2325 New Hampshire Ave Silver Spring
LENGTH OF STAY IN 1b: 55 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Colonial Villa-12325 New Hampshire Ave,

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 1206 Parker Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Julian — Middle: F. — Last: Belfield
4. DATE OF DEATH: Month: 6 — Day: 11 — Year: 19 67
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7-27-85
9. AGE (In years last birthday): 81 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Office
10b. KIND OF BUSINESS OR INDUSTRY: Post Office
11. BIRTHPLACE (County & State, or foreign country): Westmorland Co., Va..
12. CITIZEN OF WHAT COUNTRY? U.S..
13. FATHER'S NAME: LeRoy Belfield
14. MOTHER'S MAIDEN NAME: Mary Spillman
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service)
16. SOCIAL SECURITY NO: 577-52-6674
17. INFORMANT: Address: Mrs. Julian Belfield, 1206 Parker Ave., Hyattsville, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 1 day
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic cardio-vascular disease — unknown
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18.)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from 6-11, 1967, to 6-11, 1967, that (I) ~~(we)~~ last saw the deceased alive on 6-11 1967, and that death occurred at 2:40 PM, from causes and on the date stated above.

22a. SIGNATURE: Eino Magi, M.D — ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS. ☐
22b DATE SIGNED: 6-11-1967
22c. PHYSICIAN'S NAME (Type): EINO MAGI
22d. ADDRESS: 831 University Blvd. E. Silver Spring, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 6/15/67
23c NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
23d LOCATION (City or Town) (County) (State): Suitland Maryland

24. FUNERAL DIRECTOR — ADDRESS: J. Wm. Lees Sons. 300 4th St..NE. Wash., DC
25a RECD BY REGISTRAR DATE: JUN 16 1967
25b. REGISTRAR'S SIGNATURE: Frances Judge

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08301

CERTIFICATE OF DEATH

08290

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (rural)
c. LENGTH OF STAY IN 1b: 40 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Naval Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Virginia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Springfield
d. STREET ADDRESS: 7032 Beverly Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First Catherine Middle Regina Last BENNER

4 DATE OF DEATH: Month June Day 18 Year 1967

5 SEX: Female

6 COLOR OR RACE: Cauc

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: Dec. 14, 1919

9. AGE (In years last birthday): 47 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Intelligence Analyst

10b. KIND OF BUSINESS OR INDUSTRY: Government

11. BIRTHPLACE (County & State, or foreign country): Wilkes Barre, Penn.

12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edward R. McNamara

14. MOTHER'S MAIDEN NAME: Helen M. Dunphy

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)

16 SOCIAL SECURITY NO: 124-18-5442

17 INFORMANT: Springfield Address: Virginia
Mr. Bruce K. Benner, 7032 Beverly Lane

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) intra crania & hepatic metastases
DUE TO (b) jejunal carcinoma
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1527

INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May 9, 1967 to June 18, 1967, that (I) (we) last saw the deceased alive on June 18, 1967, and that death occurred at 1255P M, from causes and on the date stated above.

22a SIGNATURE: Evans Diamond, M.D. MD
ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b DATE SIGNED: June 19, 1967

22c PHYSICIAN'S NAME (Type): Evans Diamond, M. D.

22d ADDRESS: Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: June 21, 1967

23c NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery

23d LOCATION (City or Town) (County) (State): Wilkes Barre, Pennsylvania

24. FUNERAL DIRECTOR: Robert J. Murphy Funeral Home ADDRESS: 3524 Columbia Pike, Arlington, Va.

25a REC'D BY REGISTRAR DATE: JUN 21 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Jenega

VR A15 (4)
20 M 1/66

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1-3

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08302

CERTIFICATE OF DEATH

08291

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH — a. COUNTY: Montgomery — MARYLAND

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) — a. STATE: Washington, D. C. — b. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring

c. LENGTH OF STAY IN 1b: 4 years

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Sylvan Manor Nursing Home

d. STREET ADDRESS: 200 16th St., N. W.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Mamie — Middle: Doss — Last: BENNETT

4 DATE OF DEATH: Month: JUNE — Day: 20 — Year: 19 67

5 SEX: female

6 COLOR OR RACE: white

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH: Dec 5, 1865

9 AGE (In years last birthday): 101 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Resident Manager

10b. KIND OF BUSINESS OR INDUSTRY: Apt. House

11. BIRTHPLACE (County & State, or foreign country): Flord County, Alabama

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: Unknown

14 MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): None

16 SOCIAL SECURITY NO: 218-24-2386

17. INFORMANT: Mrs. Dorothy Smith — Address: Rt. 4, Box 153A Culpeper, Virginia

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I: DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Acute Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: Hours

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b): Chronic, Congestive Heart Failure

DUE TO

(c): Old Age

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ____, 19__ to 6-20, 19 67, that (I) (we) last saw the deceased alive on 6-19, 19 67, and that death occurred at 7:10 M, from causes and on the date stated above.

22a. SIGNATURE: Robert T. Thibadeau, M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6-20-67

22c. PHYSICIAN'S NAME (Type): ROBERT T. THIBADEAU

22d. ADDRESS: ROCKVILLE 20852

23a. BURIAL, CREMATION REMOVAL (Specify): Trans-burial

23b. DATE THEREOF: June 24, 1967

23c. NAME OF CEMETERY OR CREMATORY: Newbern Cemetery

23d. LOCATION (City or Town) (County) (State): Newbern, Alabama

24. FUNERAL DIRECTOR: John B. Thomas — Warner E. Pumphrey, Inc.

ADDRESS: 8434 Georgia Avenue Silver Spring, Md.

25a. REC'D BY REGISTRAR — DATE: JUN 22 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4) 20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08303 — 08292

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASH. SAN. AND HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND — b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
d. STREET ADDRESS: 7520 MAPLE AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: Valentine — Last: BerBerich
4. DATE OF DEATH: Month: June — Day: 15 — Year: 1967

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9-24-99
9. AGE (In years last birthday): 67 yrs
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED - ACCOUNTANT
10b. KIND OF BUSINESS OR INDUSTRY: - - -
11. BIRTHPLACE (County & State, or foreign country): ILLINOIS
12. CITIZEN OF WHAT COUNTRY? U.S. AMERICA

13. FATHER'S NAME: John V. Berberich, Sr.
14. MOTHER'S MAIDEN NAME: Mary Procter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes give war or dates of service): - -
16. SOCIAL SECURITY NO.: 217-44-2868
17. INFORMANT: Address: PTS CHART.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: Minutes
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): A.S.H.D. — Years
DUE TO
(c): Generalized A.S. obliterans — Years

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 4 M.I.'s in the past; Hypoalbuminemia; DIABETES MELLITUS
WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May, 1967, to 6/15, 1967, that (I) (we) last saw the deceased alive on 6/15 1967, and that death occurred at M, from causes and on the date stated above.

22a. SIGNATURE: K. Cruze — M.D. ATTENDING PHYS. ☑ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED:
22c. PHYSICIAN'S NAME (Type): DR K. CRUZE
22d. ADDRESS: 831 UNIVERSITY BLVD. E. SILVER SPRING, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6-17-1967
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
23d. LOCATION (City or Town) (County) (State): Suitland Md

24. FUNERAL DIRECTOR: Joseph Gawler's Sons, Inc.
ADDRESS: 8130 Wisc Ave. N.W. DC Wash
25a. RECD BY REGISTRAR DATE: JUN 19 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08304 Item #4 Film #G390 6/23/67 pc 08293

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) — a. STATE: D.C — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 4
d. STREET ADDRESS: 4301 Massachusetts Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: Beringer — Last:
4. DATE OF DEATH: Month: 6 — Day: 11 — Year: 19 67

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 2, 1904
9. AGE (In years last birthday): 63 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Realtor
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Illinois
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Beringer
14. MOTHER'S MAIDEN NAME: Kathryn Stand
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO:
17. INFORMANT: William J. Beringer — Address: 6403 Malone Lane Bethesda Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): METASTATIC CARCINOMA RECTUM
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): PRIMARY CARCINOMA LIVER
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH: 3 Months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from JAN, 1952, to JUNE, 1967 that (I) (we) last saw the deceased alive on June 11 1967, and that death occurred at 930 P M, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 6/11/67
22c. PHYSICIAN'S NAME (Type): BRUCE I DONOVAN
22d. ADDRESS: 8218 WISCONSIN AVE Bethesda Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6-14-1967
23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cemetery
23d. LOCATION (City or Town) (County) (State): Silver Spring, Md.

24. FUNERAL DIRECTOR: Joseph Gawler & Sons — ADDRESS: Washington D.C.
25a. RECD BY REGISTRAR DATE: JUN 20 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
25M 1/67

1 4

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08305 08294

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

Cleared by Dr Bill for signature by Dr J Smith

1 PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 2½ years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 15000 Donna Dr.

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 15000 Donna Dr
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First Richard Middle Adam Last Bettinger

4 DATE OF DEATH: Month 6 Day 4 Year 1967

5 SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 5-23-1899

9. AGE (In years last birthday): 68 yrs

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Quality Control engineer

10b KIND OF BUSINESS OR INDUSTRY: Betco Electronics

11 BIRTHPLACE (County & State, or foreign country): Ohio

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: Charles Bettinger

14. MOTHER'S MAIDEN NAME: Mary (unknown)

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO: Yes

17 INFORMANT: Richard Bettinger Address: 15000 Donna Drive Son, Silver Spring, Maryland

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Acute Coronary Occlusion
DUE TO (b): Arteriosclerotic Heart Disease
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes Mellitus

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1963, 19__ to 6/4, 1967 that (I) (we) last saw the deceased alive on 6/2/67 19, and that death occurred at 11:00 A.M. from causes and on the date stated above.

22a SIGNATURE: Joseph E. Smith Jr. M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b DATE SIGNED: 6/4/67

22c PHYSICIAN'S NAME (Type): JOSEPH E. Smith, Jr.

22d ADDRESS: Burtonsville, Md

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: June 7, 1967

23c NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cemetery

23d LOCATION (City or Town) (County) (State): Silver Spring, Maryland

24 FUNERAL DIRECTOR: C. Fred Carter Asst. Mgr. ADDRESS: 8434 Georgia Avenue
Warner E. Pumphrey, Inc. Silver Spring, Md.

25a RECD BY REGISTRAR DATE: JUN 9 1967

25b REGISTRAR'S SIGNATURE: J. Charles Judge

Item 18 Film 389 6-19-67

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08306 08295

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (rural)
c. LENGTH OF STAY IN 1b: 17 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Naval Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Alabama
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Attalla
d. STREET ADDRESS: 98 Cleburne Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Phyllis — Middle: Marilyn — Last: BIGHAM

4 DATE OF DEATH: Month: June — Day: 6 — Year: 1967

5 SEX: Female

6 COLOR OR RACE: Cauc

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 31, 1923

9. AGE (In years last birthday): 43 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (County & State, or foreign country): Denver Colorado

12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Robert Rudd

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO: NONE

17. INFORMANT: Attalla — Address: Alabama
Mr. Billy J. Bigham, 98 Cleburne St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Exsanguination intra thoracic, and retroperitoneal
DUE TO (b): Cardiac surgery with cardiopulmonary bypass
DUE TO (c): Rheumatic heart disease with mitral valvulitis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May 20, 1967, to June 6, 1967 that (I) (we) last saw the deceased alive on June 6 1967, and that death occurred at 1500 PM, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 7 June 1967

22c. PHYSICIAN'S NAME (Type): Perry Ah-TYE, M. D.

22d. ADDRESS: Naval Hospital, Bethesda, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6-8-67

23c. NAME OF CEMETERY OR CREMATORY: Attalla Cemetery

23d. LOCATION (City or Town) (County) (State): Attalla, Alabama

24. FUNERAL DIRECTOR: W. W. Chambers Co. — ADDRESS: 1400 Chapin St., N. W. Washington, D. C.

25a. RECD BY REGISTRAR DATE: JUN 9 1967

25b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08307

CERTIFICATE OF DEATH

08296

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OLNEY
c. LENGTH OF STAY IN 1b: 2 HOURS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MONTGOMERY GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND — b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SYKESVILLE
d. STREET ADDRESS: BOX 233
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: BABY — Middle: BOY — Last: BOGGS

4. DATE OF DEATH: Month: 6 — Day: 6 — Year: 19 67

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6-6-67

9. AGE (In years last birthday): yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: hours: 2 / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (County & State or foreign country): MONTGOMERY, MD.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: H. L. BOGGS

14. MOTHER'S MAIDEN NAME: DORIS ANN OLIVER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)

16. SOCIAL SECURITY NO: NONE

17. INFORMANT: MEDICAL RECORDS DEPT. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity. — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6/6/67 8:47 am 1967, to 6/6, 1967, that (I) (we) last saw the deceased alive on 6/6 1967, and that death occurred at 10 A.M. from causes and on the date stated above.

22a. SIGNATURE: H. S. Celgin MD — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): H. S. CELGIN, M. D.

22d. ADDRESS: 818 MONTGOMERY RD., ELKRIDGE, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6-12-67

23c. NAME OF CEMETERY OR CREMATORY: Red Hill

23d. LOCATION (City or Town) (County) (State): Pennington Gap Va

24. FUNERAL DIRECTOR: Luther A. Haught — ADDRESS: Sykesville, Md.

25a. REC'D BY REGISTRAR — DATE: JUN 12 1967

25b. REGISTRAR'S SIGNATURE: Charles Jones

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08308

CERTIFICATE OF DEATH

08237

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Potomac Valley Nursing Home

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D. C.
d. STREET ADDRESS: 1236 11th Street N. W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First: Margaret — Middle: M — Last: Bond

4 DATE OF DEATH: Month: June — Day: 17 — Year: 1967

5 SEX: F

6 COLOR OR RACE: W

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8 DATE OF BIRTH: May 13, 1879

9 AGE (In years last birthday): 88 yrs

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nurse

10b KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (County & State, or foreign country): Ireland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: James McNamara

14. MOTHER'S MAIDEN NAME: Margaret Bowles

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16 SOCIAL SECURITY NO: 577-44-9934A

17 INFORMANT: Sarah A. Wilson — Address: 5013 Allen Rd Yorktown, Va. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Acute Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Coronary Thrombosis — 1 day.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Arteriosclerotic Heart Disease — 10 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Partial Hemiplegia - right.

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec 1957 to June 7, 1967 that (I) (we) last saw the deceased alive on June 16 1967, and that death occurred at 2:30 PM, from causes and on the date stated above

22a SIGNATURE: E. Herbert Bauersfeld M.D — ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 6/17/67

22c. PHYSICIAN'S NAME (Type): E. Herbert Bauersfeld

22d ADDRESS: 2401 Calvert St. N.W.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 6/20/67

23c NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery

23 LOCATION (City or Town) (County) (State): Prince Georges Co. Md.

24 FUNERAL DIRECTOR: S. H. Hines Co — ADDRESS: Wash. D. C.

25a RECD BY REGISTRAR DATE: JUN 19 1967

25b REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
25M 1/67

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08303

CERTIFICATE OF DEATH

08298

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wheaton Md
c. LENGTH OF STAY IN 1b: 1 1/2 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Wheaton Nursing Home

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Washington — b. COUNTY: D.C
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
d. STREET ADDRESS: 1369 Nicholson St, NW
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Corliss — Middle: H. — Last: Bowen

4 DATE OF DEATH: Month: June — Day: 3 — Year: 1967

5 SEX: M

6 COLOR OR RACE: Cauc.

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 23 July 1890

9. AGE (In years last birthday): 76 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Wood worker

10b. KIND OF BUSINESS OR INDUSTRY: Wood working

11 BIRTHPLACE (County & State, or foreign country): Georgia

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Gilbert Bowen

14. MOTHER'S MAIDEN NAME: Edna?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service)

16 SOCIAL SECURITY NO.

17 INFORMANT — Address: Mrs. Helen M. Bowen. (same as #2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Stroke — INTERVAL BETWEEN ONSET AND DEATH: 18 months
DUE TO (b): Arteriosclerosis (generalized) — Several years
DUE TO (c): Pneumonitis, urinary tract infection — > 2 weeks.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Dec. 25, 1965 to June 3, 1967, that (I) (we) last saw the deceased alive on June 2 1967, and that death occurred at 12:45 P.M., from causes and on the date stated above.

22a. SIGNATURE: Hugo G. Graziani for O. Leach Kibble, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6/3/67

22c. PHYSICIAN'S NAME (Type): Hugo G. Graziani, MD

22d. ADDRESS: 10101 Georgia Ave, Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: June 6, 1967

23c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

23d. LOCATION (City or Town) (County) (State): Hagerstown, Md

24 FUNERAL DIRECTOR — ADDRESS: Arthur Walters, 254 Carroll St NW Washington DC

25a. REC'D BY REGISTRAR — DATE: JUN 6 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20 M 1/66

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #2 id film 5/20/67 pc

08310 **CERTIFICATE OF DEATH** 08299

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in ink by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND	2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wheaton c. LENGTH OF STAY IN 1b: 11 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): University Nursing Home	d. STREET ADDRESS: 6807 Fairfax Rd. e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Harry	Middle: F.	Last: Bowen	4. DATE OF DEATH: Month: 6	Day: 19	Year: 19 67			
5. SEX: M	6. COLOR OR RACE: Caus.	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: 3/4/1898	9. AGE (In years last birthday): 69 yrs	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maintenance Engineer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country): Parkersburg, W., Va.	12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME: John Edward Bowen	14. MOTHER'S MAIDEN NAME: Mary Gove							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)	16. SOCIAL SECURITY NO: 232-09-4971	17. INFORMANT: Nursing Home Records — Address						

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generalized Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 10 Mos.
DUE TO (b): Adenocarcinoma colon — 48 mos.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from Jan 4, 1967, to June 19, 1967 that (I) (~~me~~) last saw the deceased alive on June 17 1967, and that death occurred at 11:15 A.M. from causes and on the date stated above.

22a. SIGNATURE: Harry N Carlton, M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐ — 22b. DATE SIGNED: June 19, 1967

22c. PHYSICIAN'S NAME (Type): Dr. Harry Carlton — 22d. ADDRESS: 8811 Colesville Rd. Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal	23b. DATE THEREOF: 6/20/67	23c. NAME OF CEMETERY OR CREMATORY: Sutton Hill Cemetery	23d. LOCATION (City or Town) (County) (State): Sutton ~~Hill~~ West Va.
24. FUNERAL DIRECTOR: The S.H. Hines Co. — ADDRESS: Wash. D.C.	25a. RECD BY REGISTRAR DATE: JUN 20 1967	25b. REGISTRAR'S SIGNATURE: [illegible] Judge	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08311

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed with[in] 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: MARYLAND — 57 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross Hospital of Silver Spring

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 1712 Noyes Land
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ALBERT Middle RICHARD Last BRADLEY

4. DATE OF DEATH: Month June Day 23 Year 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9/29/05

9. AGE (In years last birthday): 61 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): GOVERNMENT. CORPS OF ENG.

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ERNEST H. BRADLEY

14. MOTHER'S MAIDEN NAME: CARRIE MAE BOLLMAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.: 578-07-7253

17. INFORMANT: KATHERYNE BRADLEY. Address: 1712 Noyes Lane S.S. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia
DUE TO (b): Carcinoma of Bladder - Metastasis
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 2 weeks 6 Months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 3/10 ..., 19 67, to 6/23 ..., 67, that (I) (we) last saw the deceased alive on 6/23 ..., 1967, and that death occured at 11:10 PM, from the causes and on the date stated above.

22a. SIGNATURE: Joseph Bloom M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Joseph Bloom

22d. ADDRESS: 1111 Spring Street Silver Spring Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 26 JUNE 1967

23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven

23d. LOCATION (City, town or county) (State): Wheaton MARYLAND

24. FUNERAL DIRECTOR'S SIGNATURE: Rinaldi Funeral Home

ADDRESS: 7480 Georgia Avenue Wash. DC

25a. REGISTRAR

25b. REG STRAR'S SIGNATURE

DATE JUN 27 1967 J. Charles Judge

1 13

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08312 08301

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HOLY CROSS HOSP

2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission)
a. STATE: MD.
b. COUNTY: MONTGOMERY.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
d. STREET ADDRESS: 3227 Blueford Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Milton G Middle: Last: Bransome

4. DATE OF DEATH: Month: June Day: 1 Year: 1967

5. SEX: M.

6. COLOR OR RACE: CAUC

7. MARRIED ☑ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Dec. 12 1921

9. AGE (In years last birthday): 45 yrs

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): OXYGEN THERAPIST

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): New Jersey

12. CITIZEN OF WHAT COUNTRY?: U. S.

13. FATHER'S NAME: D. Stanhope Bransome

14. MOTHER'S MAIDEN NAME: Isabelle Frates

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WW II

16. SOCIAL SECURITY NO: 142-07-9617

17. INFORMANT: Wife Address: Joan V. Bransome Same as Item 2.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Posterior Myocardial Infarct — INTERVAL BETWEEN ONSET AND DEATH: 17 days
DUE TO (b): Coronary artery occlusion — 12 days
DUE TO (c): Coronary artery Sclerosis — 5 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetis Mellitus

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ____, 19 63, to 1 June, 19 67, that (I) (we) last saw the deceased alive on 31 May 19 67, and that death occurred at 6:15 M, from causes and on the date stated above.

22a. SIGNATURE: Merton L. White M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 1 June 67

22c. PHYSICIAN'S NAME (Type): MERTON L. WHITE

22d. ADDRESS: 9911 Georgia Ave Silver Spring Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6-3-67

23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cem.

23d. LOCATION (City or Town) (County) (State): Silver Spring, Md.

24. FUNERAL DIRECTOR ADDRESS: ROBERT A. PUMPHREY, Bethesda, Maryland

25a. REC'D BY REGISTRAR DATE: JUN 5 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08313 08302

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages (1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Montgomery — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
   c. LENGTH OF STAY IN 1b: 1 hr 28 min
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) — a. STATE: Virginia — b. COUNTY:
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Springfield
   d. STREET ADDRESS: 5409 Juliet Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Baby — Middle: Boy — Last: Brown

4. DATE OF DEATH: Month: June — Day: 21 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: Cauc

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 21, 1967

9. AGE (In years lost birthday) yrs

IF UNDER 1 YEAR — Months: — Days: — IF UNDER 24 HRS — Hours: 1 — Min: 28

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): N/A

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State or foreign country): Montgomery

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Lee Brown

14. MOTHER'S MAIDEN NAME: Joy Ballauf

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): N/A (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: N/A

17. INFORMANT: Springfield — Address: Virginia
LtCdr Lee Brown, USN, 5409 Juliet Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1041 21 Jun 19 67, to 1209 21 Jun 19 67, that (I) (we) last saw the deceased alive on 21 June 1967, and that death occurred at 1209 P.M. from causes and on the date stated above.

22a. SIGNATURE: T. E. Kelly — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: June 23, 1967

22c. PHYSICIAN'S NAME (Type): T. E. KELLY, M. D.

22d. ADDRESS: Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Transfer

23b. DATE THEREOF:

23c. NAME OF CEMETERY OR CREMATORY: Naval Medical School

23d. LOCATION (City or Town) (County) (State): NNMC, Bethesda, Md.

24. FUNERAL DIRECTOR — ADDRESS

25a. REC'D BY REGISTRAR — DATE: JUN 29 1967

25b. REGISTRAR'S SIGNATURE:

VR A15 (4)
20 M 1/66

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08314

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08303

1. PLACE OF DEATH
   a. COUNTY: Montgomery — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 705 Crabb Ave

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
   a. STATE: Maryland. b. COUNTY: Montgomery
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville — 15.1
   d. STREET ADDRESS: 705 Crabb Ave
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James — Middle: Allen. — Last: Brown

4. DATE OF DEATH: Month: June — Day: 4 — Year: 1967

5. SEX: M.

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 17 1947

9. AGE (In years last birthday): 20 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph T Brown

14. MOTHER'S MAIDEN NAME: Virginia Derry

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 219-46-8572

17. INFORMANT — Address: Joseph T. Brown - father same # 2 item

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Decompensation — INTERVAL BETWEEN ONSET AND DEATH: Hours
DUE TO (b): Valvular Heart Disease. — years
DUE TO (c):
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last: 421.4

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G. Ball M.D.
EXAMINER'S NAME (Type): John G. Ball
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):

22. DATE SIGNED: 6/4/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6/7/67

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill

23d. LOCATION (City or Town) (County) (State): Prince George Co., Md.

24. FUNERAL DIRECTOR — ADDRESS: Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Maryland

25a. REC'D BY REGISTRAR — DATE: JUN 8 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08316

CERTIFICATE OF DEATH

08304

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 4 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Dr. Kilgour's Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg
d. STREET ADDRESS: Route 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: John — Middle: Tillman — Last: Burdette

4. DATE OF DEATH: Month: June — Day: 2 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12/22/1899

9. AGE (In years last birthday): 67 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Contractor Builder

10b. KIND OF BUSINESS OR INDUSTRY: Contractor

11. BIRTHPLACE (County & State, or foreign country): Montgomery, Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John J. Burdette

14. MOTHER'S MAIDEN NAME: Long, Cora

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 521 32 3178

17. INFORMANT: Dorcas V. Burdette, Address: Item 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 3 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): ASCVD
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Bilateral CVA, Chronic pyelonephritis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour, a.m. p.m. — Month, Day, Year

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec. 1966 to June 2, 1967, that (I) (we) last saw the deceased alive on June 1, 1967, and that death occurred at 7:35 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Frederick Moonau M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6-2-67

22c. PHYSICIAN'S NAME (Type): Frederick Moonau

22d. ADDRESS: Medical Center, Sandy Spring, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: June 5, 1967

23c. NAME OF CEMETERY OR CREMATORY: Wesley Grove

23d. LOCATION (City, town or county) (State): Woodfield, Md.

24 FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Olin L. Molesworth, Damascus, Md.

25a. REC'D BY REGISTRAR DATE: JUN 6 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1-12

FOR STATE HEALTH DEPT.

M

97

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08317 08305

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 20 d

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital
d. STREET ADDRESS: 4914 Flanders Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: James Middle: Calvin Last: Burgess

4. DATE OF DEATH: Month: June Day: 3 Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan-18-1896

9. AGE (In years last birthday): 71 yrs

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Telephone Lineman

10b. KIND OF BUSINESS OR INDUSTRY: Telephone Co.

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Samuel Burgess

14. MOTHER'S MAIDEN NAME: Sarah Finley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: Son - J. Earl Burgess - 6610 Jury Place Address: McLean, Virginia

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Coronary Insufficiency Acute — INTERVAL BETWEEN ONSET AND DEATH: Sudden
4201
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G. Ball M.D.
EXAMINER'S NAME (Type): John G. Ball
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)

22. DATE SIGNED: 6/3/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6-6-67
23c. NAME OF CEMETERY OR CREMATORY: National Memorial Park
23d. LOCATION (City or Town) (County) (State): Falls Church Fairfax, Virginia

24. FUNERAL DIRECTOR: Ives Funeral Home, Inc. by: [signature] ADDRESS: 2847 Wilson Blvd, Arlington, Va. 22201

25a. RECD BY REGISTRAR DATE: JUN 6 1967

25b. REGISTRAR'S SIGNATURE: [signature]

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M 08318

CERTIFICATE OF DEATH

08306

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b: 6 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): FAIRLAND NURSING HOME 2101 FAIRLAND RD

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON GROVE
d. STREET ADDRESS: 114 RIDGE ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: MARTHA — Middle: E — Last: BURKETT

4. DATE OF DEATH: Month: JUNE — Day: 12 — Year: 1967

5 SEX: FEMALE

6 COLOR OR RACE: WHITE

7 MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 07-25-87

9 AGE (In years last birthday): 79 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (County & State, or foreign country): VIRGINIA

12 CITIZEN OF WHAT COUNTRY?: USA

13 FATHER'S NAME: NOAH KNUPP

14 MOTHER'S MAIDEN NAME: LEHR

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes give war or dates of service):

16 SOCIAL SECURITY NO.: 217-05-2635-B

17 INFORMANT: Hinckley Burkett — Address: Detour, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Septicemia
DUE TO
(b): Urinary tract infection
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Brain Syndrome

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year, Hour o.m. p.m.

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6-7, 1967 **to** 6-12, 1967, **that (I) (we) last saw the deceased alive on** 6-8 1967, **and that death occurred at** 1050 **M, from causes and on the date stated above**

22a. SIGNATURE: Gilbert B. Cushner M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b DATE SIGNED: 6-12-67

22c. PHYSICIAN'S NAME (Type): Gilbert B. Cushner, M.D.

22d. ADDRESS: 6450 New Hampshire Ave, T. Park, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 6-16-67

23c NAME OF CEMETERY OR CREMATORY: Forest Oak

23d LOCATION (City or Town) (County) (State): Gaithersburg Monty Md

24 FUNERAL DIRECTOR: Ernest C. Gartner — **ADDRESS**: Ernest C. Gartner Funeral Home Gaithersburg Md

25a RECD BY REGISTRAR DATE: JUN 15 1967

25b REGISTRAR'S SIGNATURE: Charles Jones

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in bay event, within 72 hours after death.

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08315

CERTIFICATE OF DEATH

08307

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 7 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Montgomery General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Woodfield, RFD Gaithersburg, Maryland.
d. STREET ADDRESS: Route # 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MERTIE Middle VIRGINIA Last BURNS

4. DATE OF DEATH: Month June Day 25 Year 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 3, 1917

9. AGE (In years last birthday): 49 yrs

IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Norman L. Duvall

14. MOTHER'S MAIDEN NAME: Hilda P. Burns

15. WAS DECEASED EVER IN U.S ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Family and Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Sarcomatosis — INTERVAL BETWEEN ONSET AND DEATH: Months ?
DUE TO: with Right Ventricular Failure — Minutes
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO:
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): No accident involved.

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from Feb. 11, 1967, to June 25, 1967, that (I) ~~(We)~~ last saw the deceased alive on June 25, 1967, and that death occurred at 6 P. M, from causes and on the date stated above.

22a. SIGNATURE: M. McKendree Boyer M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: June 26, 1967

22c. PHYSICIAN'S NAME (Type): M. McKendree Boyer M. D.

22d. ADDRESS: 9701 Church Street Damascus, Maryland.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: June 28,1967

23c. NAME OF CEMETERY OR CREMATORY: Wesley Grove Meth.

23d. LOCATION (City or Town) (County) (State): Woodfield, Md.

24. FUNERAL DIRECTOR: Olin L. Molesworth, ADDRESS: Damascus, Md.

25a. REC'D BY REGISTRAR DATE: JUN 29 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08319

CERTIFICATE OF DEATH

08308

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Carroll Hall Sanitarium 10231 Carroll Pl.

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D.C.
d. STREET ADDRESS: 6432 Barnaby St. N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First: Deborah — Middle: — Last: Burrowes

4 DATE OF DEATH: Month: June — Day: 11 — Year: 19 67

SEX	6 COLOR OR RACE	7 MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8 DATE OF BIRTH	9 AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min.
female	white	NEVER MARRIED ☒	2/25/77	90 yrs		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Library assistant-U.S. Government
10b KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (County & State, or foreign country): New Jersey
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: Thomas Burrowes
14 MOTHER'S MAIDEN NAME: Amanda Herbert

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17 INFORMANT — Address: Elizabeth Coffin same as #2

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH: 2 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
2) Cerebral Vascular Accident acc to HSVD 3) Carcinoma, Breast, Rt

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from June 2, 1967, to 11, 1967, that (I) (~~we~~) last saw the deceased alive on June 10 1967, and that death occurred at 8:45 p.m. from causes and on the date stated above.

22a. SIGNATURE: W. F. Cresswell, Jr.
M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: June 11 1967
22c. PHYSICIAN'S NAME (Type): W.F. Cresswell, Jr.
22d. ADDRESS: 2020 Que St. N.W.

23a BURIAL, CREMATION, REMOVAL (Specify): cremation
23b. DATE THEREOF: 6/12/67
23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Crematory
23d LOCATION (City or Town) (County) (State): Prince Georges County, Md

24. FUNERAL DIRECTOR — ADDRESS: The S.H. Hines Company 2901 14th St. N.W. Washington, D.C.
25a. REC'D BY REGISTRAR DATE: JUN 14 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08320 — 08309 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 1½ hours
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Holy Cross Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 2004 August Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Ida — Middle: M. — Last: Carlson

4. DATE OF DEATH: Month: June — Day: 6, — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 18, 1893

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Richard H. Walter

14. MOTHER'S MAIDEN NAME: Viola M. Mc Donald

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 578-24-3999

17. INFORMANT: Hugo H. Carlson — Address: 2004 August Drive, Silver Spring, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CORONARY THROMBOSIS, Acute — INTERVAL BETWEEN ONSET AND DEATH: 1 HR
4201
DUE TO (b): CORONARY HEART DISEASE — 3 YEARS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): ARTERIOSCLEROSIS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): DIABETES MELLITUS

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. / p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 1952, 19__, to 6-6-, 1967, that I last saw the deceased alive on 5-9-, 1967, and that death occurred at 2:00 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Samuel A. Hillman MD
ADDRESS (Street, city or town, state): 8829 Flower Avenue, Silver Spring, Maryland 20901
DATE SIGNED: 6/6/67

PHYSICIAN'S NAME (Type): Samuel A. Hillman, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: June 9, 1967
22c. NAME OF CEMETERY OR CREMATORY: Amissville Methodist Cemetery
22d. LOCATION (City, town, or county) (State): Amissville, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Glen Cole
Warner E. Pumphrey, Inc.
ADDRESS: 8434 Georgia Avenue, Silver Spring, Md.

24a. REC'D BY REGISTRAR DATE: JUN 12 1967

24b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER NOTIFIED WILL APPROVE

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08321 08310

CERTIFICATE OF DEATH

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page [redacted] be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7 61

1. **PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 12 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 12240 Viers Mill Road

2. **USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 12240 Viers Mill Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: David — Middle: Franklin — Last: Carraway

4. **DATE OF DEATH**: Month: June — Day: 27 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept 16, 1903

9. AGE (In years last birthday): 63 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Pf. Photographer

10b. KIND OF BUSINESS OR INDUSTRY: Dept of Agriculture

11. BIRTHPLACE (County & State, or foreign country): Gastonia, North Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Leake Carraway

14. MOTHER'S MAIDEN NAME: Mabel J. Glenn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Evelyn B. Carraway — Address: 12240 Viers Mill Road Silver Spring, Maryland

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Massive myocardial infarct — INTERVAL BETWEEN ONSET AND DEATH: minutes

DUE TO (b): Coronary occlusion — minutes

DUE TO (c): Arteriosclerosis — years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 2

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. / p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from May, 1949 to July 27, 1967, that (I) (we) last saw the deceased alive on June 20, 1967, and that death occured at 2 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Richard P. Delaney M.D.

22b. DATE SIGNED: June 27, 1967

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): Richard P. Delaney

22d. ADDRESS: 4323 Havard St., Silver Spring, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: June 29, 1967

23c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery

23d. LOCATION (City, town or county) (State): Rockville, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Glen Carter Clabaugh — ADDRESS: 8434 Georgia Avenue

Warner E. Pumphrey, Inc. Silver Spring, Md.

25a. REC'D BY REGISTRAR DATE: JUN 29 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08322 — 08311

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Echo
c. LENGTH OF STAY IN Md.: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 6105 Yale Ave.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Echo
d. STREET ADDRESS: 6105 Yale Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: BERNARD — Middle: H. — Last: CARROLL

4. DATE OF DEATH: Month: June — Day: 8, — Year: 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept. 2, 1898
9. AGE (In years last birthday): 68 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pharmacist
10b. KIND OF BUSINESS OR INDUSTRY: Drugs
11. BIRTHPLACE (County & State, or foreign country): Vermont
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Leroy Carroll
14. MOTHER'S MAIDEN NAME: Josie Babcock

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: 022-09-3337
17. INFORMANT: Lois L. Carroll — Address: Item # 2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Recurrent Cerebral vascular accident	24 hours
DUE TO (b)	Cerebral arteriosclerosis	Many years
DUE TO (c)	Generalized Atherosclerosis	Many years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diverticulitis & Rupture into bladder - Resected in 3 Stages

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Aug. 1966 to 6/8 1967 that (I) (~~was~~) last saw the deceased alive on 5/17 1967, and that death occured at 7:45 A.M. from the causes and on the date stated above.

22a. SIGNATURE: R A Williams — M.D
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 6/8/67
22c. PHYSICIAN'S NAME (Type): ROGER S. WILLIAMS
22d. ADDRESS: 35 NEW YORK AVE NW WASH DC

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6/12/67
23c. NAME OF CEMETERY OR CREMATORY: Parklawn
23d. LOCATION (City, town or county) (State): Rockville, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.
25a. REC'D BY REGISTRAR DATE: JUN 15 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 is to be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1 8

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08323 08312

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Montgomery — MARYLAND; b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda; c. LENGTH OF STAY IN 1b; d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) — a. STATE: Maryland; b. COUNTY: Montgomery; c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda; d. STREET ADDRESS: 10527 Montrose Ave; e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Ivan; Middle: Wildermer; Last: Carlsen

4. DATE OF DEATH: Month: June; Day: 4; Year: 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7-30-02

9. AGE (In years last birthday): 64 yrs

IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Topeka Kansas

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Charles Carlsen

14. MOTHER'S MAIDEN NAME: Freda Bozard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes give war or dates of service):

16. SOCIAL SECURITY NO: 709-14-2428

17. INFORMANT: Address: Lilia Carlsen - wife - add. same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Pulmonary Ca
DUE TO
(b): Ca Rectum
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
154 X

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Perforation duodenal ulcer with generalized Peritonitis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year; Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 2-26, 1965 to 6-4, 1967, that (I) (we) last saw the deceased alive on 6-4-1967, and that death occurred at 6/4 10:10 PM, from causes and on the date stated above.

22a. SIGNATURE: Drs Norman Carter + Smith R. Smith — M.D — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6-5-67

22c. PHYSICIAN'S NAME (Type): R. Smith

22d. ADDRESS: 916-19th St NW Wash DC

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6/8/67

23c. NAME OF CEMETERY OR CREMATORY: Parklawn

23d. LOCATION (City or Town) (County) (State): Rockville, Md.

24. FUNERAL DIRECTOR — ADDRESS: Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.

25a. RECD BY REGISTRAR — DATE: JUN 8 1967

25b. REGISTRAR'S SIGNATURE: Florence Judge

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08324

CERTIFICATE OF DEATH

08313

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Suburban

2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 8514 Woodhaven Blvd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: RICHARD — Middle: R — Last: CHENOWITH
4. DATE OF DEATH: Month: JUNE — Day: 17 — Year: 1967

5 SEX: Male
6. COLOR OR RACE: White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 7/24/1889
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b KIND OF BUSINESS OR INDUSTRY: Oil Dealer
11 BIRTHPLACE (County & State, or foreign country): Brooklyn New York
12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Richard R. Chenowith
14 MOTHER'S MAIDEN NAME: Adelaide Hall Tucker

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16 SOCIAL SECURITY NO: 579-05-8634
17. INFORMANT: Wife - Ann M Chenowith — Address: Same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Thrombosis of Mesenteric and Rt. Iliac Arteries
DUE TO (b): Atherosclerosis — INTERVAL BETWEEN ONSET AND DEATH: years
DUE TO (c): Diabetes mellitus — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
26 X

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Bronchopneumonia
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED Where at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11 June, 1967, to 17 June, 1967, that (I) (we) last saw the deceased alive on 16 June 1967, and that death occurred at 0125 AM, from causes and on the date stated above.

22a. SIGNATURE: Stanley M. Bialek — M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b DATE SIGNED: 17 June 67
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS: 8218 Wisc. Ave. Bethesda, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Removal
23b DATE THEREOF: 6-20-1967
23c NAME OF CEMETERY OR CREMATORY: New Cathedral Cemetery
23d LOCATION (City or Town) (County) (State): Baltimore Md

24 FUNERAL DIRECTOR: Joseph Gawler's Sons, Inc.
ADDRESS: 5130 Wisc. Ave. N.W. Wash. D.C.
25a. RECD BY REGISTRAR DATE: JUN 26 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08325

CERTIFICATE OF DEATH

08314

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY CO MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): RESMOR SANATARIUM

2. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 8425 Woodcliff Court
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ruth Middle: ANN Last: CISAR

4. DATE OF DEATH: Month: June Day: 17 Year: 1967

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec 11, 1907

9. AGE (In years last birthday): 59 yrs

IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS: Hours: Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stenographer

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Govt.

11. BIRTHPLACE (County & State, or foreign country): South Dakota

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John C CISAR

14. MOTHER'S MAIDEN NAME: Elizabeth Schock

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): None

16. SOCIAL SECURITY NO.: 577-48-6984

17. INFORMANT: Frank A. Cisar Address: 8425 Woodcliff Court Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cancer of Liver
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 4 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan, 1965 to 6/17, 1967, that (I) (we) last saw the deceased alive on 6/17 1967, and that death occurred at 3:45 P.M., from causes and on the date stated above.

22a. SIGNATURE: [signature]

M.D ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6/17/67

22c. PHYSICIAN'S NAME (Type): BLAINE T EIG

22d. ADDRESS: 6641 Colesville Rd Silver Spring Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE THEREOF: June 20, 1967

23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Crematory

23d. LOCATION (City or Town) (County) (State): Prince Georges Co., Md.

24a. FUNERAL DIRECTOR: John B. Thomas, Warner E. Pumphrey, Inc.

ADDRESS: 8434 Georgia Avenue Silver Spring, Md.

25a. RECD BY REGISTRAR DATE: JUN 21 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

1 — 4

FOR STATE HEALTH DEPT. M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08326

08315

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH
a COUNTY: Montgomery — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c LENGTH OF STAY IN 1b: D. O. A.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a STATE: Maryland — b COUNTY: Montgomery
c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Silver Spring
d STREET ADDRESS: 2814 Urbana Dr.
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross Hosp.

3 NAME OF DECEASED (Type or print): First: Edward — Middle: Ernest — Last: Clark

4 DATE OF DEATH: Month: June — Day: 13 — Year: 19 67

5 SEX: Male

6 COLOR OR RACE: Cau

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 4/27/87

9 AGE (In years last birthday): 80 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired engineer Washington Terminal

10b KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (State or foreign country): Manassas, Va.

12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: William Anson Clark

14 MOTHER'S MAIDEN NAME: Emma Bryant

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service): None

16 SOCIAL SECURITY NO.: None

17 INFORMANT (Name, address): Mrs. Edward E. Clark, wife — 2814 Urbana Dr., S. S., Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Acute Coronary Insufficiency
DUE TO (b): Arteriosclerotic Heart Disease
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part I of item 18.)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Belden R. Keap M.D.

EXAMINER'S NAME (Type): BELDEN R. KEAP M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street & No., town, or county): Silver Spring

22. DATE SIGNED: 6/19/1967

23a BURIAL CREMATION REMOVAL (Specify): Burial

23b DATE THEREOF: June 21, 1967

23c NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery

23d LOCATION (City or town) (County) (State): Suitland, Maryland

24 FUNERAL DIRECTOR: John B. Thomas, Funeral Home — ADDRESS: 8434 Georgia Avenue, Warner E. Pumphrey, Inc. Silver Spring, Md.

25a RECD BY REGISTRAR DATE: JUN 22 1967

25b REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5) 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08327

CERTIFICATE OF DEATH

08316

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 26 hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium and Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Adelphi
d. STREET ADDRESS: 2209 Metzerott Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edwin — Middle: Terrell — Last: Clarke

4. DATE OF DEATH: Month: June — Day: 6 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 24, 1895

9. AGE (In years last birthday): 72 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Planner & Estimator

10b. KIND OF BUSINESS OR INDUSTRY: NOL

11. BIRTHPLACE (County & State, or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: United States

13. FATHER'S NAME: John W. Clarke

14. MOTHER'S MAIDEN NAME: Ida Perkins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes give war or dates of service): Army - WWI

16. SOCIAL SECURITY NO: 049-05-9697A

17. INFORMANT: Mrs. Mildred Clarke — Address: 2209 Metzerott Rd. Adelphi, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 7-8 hrs.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b)
DUE TO
(c)
4251

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 6-5, 1967 to 6-6, 1967 that (I) (~~we~~) last saw the deceased alive on 6-6 1967 and that death occurred at 12:02 P.M. from causes and on the date stated above.

22a. SIGNATURE: Jason Geiger, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6-6-67

22c. PHYSICIAN'S NAME (Type): Jason Geiger, M.D.

22d. ADDRESS: 800 Pershing Drive Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: June 9, 1967

23c. NAME OF CEMETERY OR CREMATORY: Arlington Nat'l. Cemetery

23d. LOCATION (City or Town) (County) (State): Arlington, Virginia

24. FUNERAL DIRECTOR: Warner E. Pumphrey, Inc. — ADDRESS: 8434 Georgia Avenue Silver Spring, Md.

25a. RECD BY REGISTRAR DATE: JUN 12 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08328

CERTIFICATE OF DEATH

08317

1 PLACE OF DEATH
a. COUNTY: Montgomery Cty — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring Md.
c. LENGTH OF STAY IN 1b: 5 weeks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Md.
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): XXXXXXXXXXXXXXXXXXXX Silver Spring
d. STREET ADDRESS: 10229 Capital View Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: BEATA Middle: Gladys Last: COFFEE

4. DATE OF DEATH: Month: June Day: 11 Year: 1967

5. SEX: F
6. COLOR OR RACE: W.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: 11-16-85
9. AGE (In years last birthday): 81 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of work ng life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (County & State, or foreign country): Milan Indiana (Ripley County)
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Charles Joseph Peters
14. MOTHER'S MAIDEN NAME: Jessie F. Sutton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes give war or dates of service): None
16. SOCIAL SECURITY NO.: 218-54-6143
17. INFORMANT (Informant): (Daughter) Address: Lois CAIN - 10229 Capital View Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): E Coli SEPTICEMIA — INTERVAL BETWEEN ONSET AND DEATH: 1 DAY
DUE TO (b): GENERALIZED PERITONITIS — 5 DAYS
DUE TO (c): STATUS POST RESECTION-CARCINOMA COLON — 2 WEEKS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5-6-1967 to 6-11, 1967 that (I) (we) last saw the deceased alive on 6-11-1967, and that death occurred at 11:45 M, from causes and on the date stated above.

22a. SIGNATURE: John P. Haberlin M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 6-12-67
22c. PHYSICIAN'S NAME (Type): John P. Haberlin
22d. ADDRESS: 1015 Spring St., Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Trans-Burial
23b. DATE THEREOF: June 15, 1967
23c. NAME OF CEMETERY OR CREMATORY: Stumpkes Corner Cemetery
23d. LOCATION (City or Town) (County) (State): Milan, Indiana

24. FUNERAL DIRECTOR: C. Glen Carter C Glen Carter
ADDRESS: 8434 Georgia Avenue
Warner E. Pumphrey, Inc. Silver Spring, Md.

25a. RECD BY REGISTRAR DATE: JUN 14 1967
25b. REGISTRAR'S SIGNATURE: Jeanne Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08329 — 08318

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
25M 1/67

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: weeks

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: New Jersey
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Trenton

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium & Hospital
d. STREET ADDRESS: 263 Ellicott
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Mabel — Middle: L — Last: Caley
4. DATE OF DEATH: Month: June — Day: 3 — Year: 19 67

5. SEX: F
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug 7, 1913
9. AGE (In years last birthday): 53 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Office Worker
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country)
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Joseph Caley
14. MOTHER'S MAIDEN NAME: Ina Carr

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT — Address: Washington Sanitarium Hospital Takoma

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic Spine — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs
DUE TO
170X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Carcinoma of Breast
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3/22/67, 19__ to 6/3, 1967, that (I) (we) last saw the deceased alive on 6/3 19 67, and that death occurred at 12:10 P.M., from causes and on the date stated above.

22a. SIGNATURE: Raymond West — M.D. ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: June 3, 1967
22c. PHYSICIAN'S NAME (Type): RAYMOND O WEST
22d. ADDRESS: 831 University Blvd E., Silver Spring Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6/6/67
23c. NAME OF CEMETERY OR CREMATORY: Greenwood Cemetery
23d. LOCATION (City or Town) (County) (State): Trenton, New Jersey

24. FUNERAL DIRECTOR — ADDRESS: Arthur Walters, 254 Carroll St NW Wash. D.C.
25a. RECD BY REGISTRAR — DATE: JUN 6 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

Items 18&21 Film 390
7-11-67 ams

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08330

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08319

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Wash San't Hospital

2 USUAL RESIDENCE (Where deceased lived, If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
d. STREET ADDRESS: 6701 Westmoreland
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Marie — Middle: G. — Last: Collins
4 DATE OF DEATH: Month: 6 — Day: 9 — Year: 1967
5 SEX: Female
6. COLOR OR RACE: White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 9-16-16
9 AGE (In years last birthday): 50 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker
10b KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Washington D C
12 CITIZEN OF WHAT COUNTRY? U.S.A.
13 FATHER'S NAME: John B. Gleason
14 MOTHER'S MAIDEN NAME: Annie Marie Brenahan
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16 SOCIAL SECURITY NO.
17. INFORMANT — Address: Son-Bernard Collins

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) (Pending) / Acute fatty metamorphosis of liver — INTERVAL BETWEEN ONSET AND DEATH
581.1
DUE TO
(b) Malnutrition and chronic alcoholism
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)
20c TIME OF INJURY Month Day Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒ Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G. Ball MD
EXAMINER'S NAME (Type): JOHN G. BALL
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
22. DATE SIGNED: 6/9/67

23a BURIAL, CREMATION, REMOVAL, Specify: Burial
23b DATE THEREOF: June 12 1967
23c NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
23d LOCATION (City or Town) (County) (State): Suitland, Pr. Geo. Md.
24 FUNERAL DIRECTOR: J. Arthur Walters — ADDRESS: 254 Carroll St NW DC
25a RECD BY REGISTRAR DATE: JUN 12 1967
25b REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5)
6M 1/67

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08331 08320

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (rural)
c. LENGTH OF STAY IN 1b: 43 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: ~~District of Columbia~~
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 4704 Brinkley Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Jeanne — Middle: Wilson — Last: COLVIN

4. DATE OF DEATH: Month: June — Day: 22 — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: Cauc

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 15, 1931

9. AGE (In years last birthday): 35 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teacher/Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country): Pittsburg, Pennsylvania

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Samuel Wilson

14. MOTHER'S MAIDEN NAME: Emma Vandegrift

15. WAS DECEASED EVER IN U.S ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO

17. INFORMANT: Washington, D.C. Address: 20031
LCol H. Clifford Colvin, 4704 Brinkley Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Massive subarachnoid and subdural hemorrhage
DUE TO (b): secondary to hemorrhagic diathesis associated with
Conditions, if ony, which gove rise to immediate cause (a), stating the underlying couse last
DUE TO (c): lymphosarcoma

INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 **I certify** that (I) (this hospital) attended the deceased from May 10, 19 67, to June 22, 19 67, that (I) (we) last saw the deceased alive on June 22 19 67, and that death occurred at 725 PM, from causes and on the date stated above.

22a. SIGNATURE: David R. Foreman M.D — ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: June 23, 1967

22c. PHYSICIAN'S NAME (Type): Davis R. Foreman, M. D.

22d. ADDRESS: Navy Hospital, Bethesda, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6-26-67

23c. NAME OF CEMETERY OR CREMATORY: Arlington National

23d LOCATION (City or Town) (County) (State): Arlington, Virginia

24. FUNERAL DIRECTOR: Robert A. Pumphrey ADDRESS: Funeral Home, 7557 Wisconsin Ave., Bethesda, Md

25a. REC'D BY REGISTRAR DATE: JUN 27 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08321

08332

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 36 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 10009 Greenock Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Curtis — Middle: Carl — Last: Combs

4. DATE OF DEATH: Month: June — Day: 23 — Year: 1967

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5-21-13

9. AGE (In years last birthday): 54 yrs
IF UNDER 1 YEAR: Months: — Days: 2
IF UNDER 24 HRS: Hours: — Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TEACHER

10b. KIND OF BUSINESS OR INDUSTRY: Public Schools

11. BIRTHPLACE (County & State or foreign country): Titus Co. Texas

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Oscar Combs

14. MOTHER'S MAIDEN NAME: Tommie Stevens

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): None

16. SOCIAL SECURITY NO: 577-24-6782

17. INFORMANT: Mrs Wilma Combs (wife) — Address: 10009 Greenock Rd Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Bronchitis & Emphysema — INTERVAL BETWEEN ONSET AND DEATH: 2yrs
DUE TO (b): Pseudomonas — 1yr
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Nov 1, 1966, to June 23, 1967, that (I) (we) last saw the deceased alive on June 22, 1967, and that death occurred at 6A M, from causes and on the date stated above.

22a. SIGNATURE: Robert C. Macon, M.D. — ATTENDING PHYS. ☑ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 6/23/67

22c. PHYSICIAN'S NAME (Type): Robert C. Macon M.D.

22d. ADDRESS: 809 Viers Mill Road, Rockville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Trans-burial

23b. DATE THEREOF: June 27, 1967

23c. NAME OF CEMETERY OR CREMATORY: [redacted]

23d. LOCATION (City or Town) (County) (State): Mt. Pleasant, Texas

24. FUNERAL DIRECTOR: C. Glen Carter — ADDRESS: 8434 Georgia Avenue
Warner E. Pumphrey, Inc. Silver Spring, Md.

25a. RECD BY REGISTRAR DATE: JUN 28 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08333 — 08322

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Montgomery — MARYLAND
   b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Bethesda
   c. LENGTH OF STAY IN (a): 1 month
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission)
   a. STATE: Maryland — b. COUNTY: Montgomery
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
   d. STREET ADDRESS: 7415 Oak Lane
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Myrta — Middle: Vogel — Last: Cosno
4. DATE OF DEATH: Month: June — Day: 4 — Year: 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7-2-83
9. AGE (In years last birthday): 83 yrs
   IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Cheboygan - Michigan
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles W. Vogel
14. MOTHER'S MAIDEN NAME: Elizabeth Neuffer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 217-36-5744
17. INFORMANT: Mr. George H. Cosno — Address: [illegible]

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Arteriosclerotic Cerebrovascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 4 yrs.
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 334X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18): Fell at home - causing Fracture of Hip + Wrist.
20c. TIME OF INJURY Month, Day, Year: Hour 10 30 am pm — 5/3 1967
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home -
20f. (City or Town) (County) (State): Chevy Chase Montg. Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from. Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G Ball M.D.
EXAMINER'S NAME (Type): JOHN G. BALL
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22. DATE SIGNED: 6/4/67
Address (Street, city, town, or county): Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6-7-67
23c. NAME OF CEMETERY OR CREMATORY: Forest Hills Cemetery
23d. LOCATION (City or Town) (County) (State): Ann Arbor Mich

24. FUNERAL DIRECTOR: Robert A Rumphrey — ADDRESS: 7557 Wisc Ave Bethesda. Md.

25a. RECD BY REGISTRAR — DATE: JUN 8 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15ME (5)
6M 1/67

1 3

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08334 — 08323

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 3 wks.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 4720 Chevy Chase Drive

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 4720 Chevy Chase Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Adele — Middle: Beall — Last: Curran.
4. DATE OF DEATH: Month: 6 — Day: 8 — Year: 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6-8-88
9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home Maker
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (County & State, or foreign country): Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph M. Curran
14. MOTHER'S MAIDEN NAME: Maty Catherine Devine

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown): No — (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 579-60-9100
17. INFORMANT: Miss Mildred Burrows — Address: 4720 Ch. Ch. Dr. Bethesda Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 6 hrs.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arterio-sclerosis, severe with Coronary sclerosis — 10 yrs.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Rheumatic mitral disease, mild
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from Aug 3, 1956 to June 8, 1967, that (I) ~~(we)~~ last saw the deceased alive on June 8 1967, and that death occurred at 9.15 P.M. from causes and on the date stated above.

22a. SIGNATURE: Thomas A. Wildman, M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: June 8, 1967
22c. PHYSICIAN'S NAME (Type): THOMAS A. WILDMAN
22d. ADDRESS: 3729 Morrison St. NW. Wash. DC.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6-13-67
23c. NAME OF CEMETERY OR CREMATORY: Holy Rood Cemetery
23d. LOCATION (City or Town) (County) (State): Washington, D. C.

24. FUNERAL DIRECTOR ADDRESS: ROBERT A. PUMPHREY, Bethesda, Maryland
25a. RECD BY REGISTRAR DATE: JUN 16 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08335 **CERTIFICATE OF DEATH** 08324

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 1 month
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross Hospital of Silver Spring

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 14507 Fairhaven Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Carolyn — Middle: — Last: Davis

4. DATE OF DEATH: Month: June — Day: 19 — Year: 19 67

5. SEX: F

6. COLOR OR RACE: Cauc

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9/16/23

9. AGE (In years last birthday): 43 yrs

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Physicist- Naval Ord. Lab.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Potts. Pa.

12. CITIZEN OF WHAT COUNTRY? U.S/A.

13. FATHER'S NAME: Donald G. Lerch

14. MOTHER'S MAIDEN NAME: Ann Leister

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: Same as #2d — Address: John R. Davis, Jr. Husband

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hepatic Failure — INTERVAL BETWEEN ONSET AND DEATH: WEEKS
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Adenocarcinoma of Colon due to 1538 — 7 + 10 yrs.
DUE TO
(c): Ulcerative Colitis — many yrs

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from ____, 1963, to 6/19, 1967, that (I) (we) last saw the deceased alive on 6/19 19 67, and that death occurred at 5:00 AM, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 6/19/67

22c. PHYSICIAN'S NAME (Type):

22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE THEREOF: 6-20-67

23c. NAME OF CEMETERY OR CREMATORY: Lee's Crematory

23d. LOCATION (City or Town) (County) (State): Washington, D.C.

24. FUNERAL DIRECTOR: Lee Funeral Home — ADDRESS: Washington, D.C.

25a. REC'D BY REGISTRAR DATE: JUN 21 1967

25b. REGISTRAR'S SIGNATURE: [signature]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08336

CERTIFICATE OF DEATH

08325

1 PLACE OF DEATH
a COUNTY Montgomery MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda
c LENGTH OF STAY IN 1b 14 days
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban

2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE Md. b COUNTY Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg
d STREET ADDRESS Rt. #1-Box 404
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First James Middle Franklin Last Day
4 DATE OF DEATH Month 6 Day 11 Year 1967
5. SEX M
6. COLOR OR RACE W
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 7-2-1885
9 AGE (In years last birthday) 81 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10b. KIND OF BUSINESS OR INDUSTRY Laborer
11 BIRTHPLACE (County & State, or foreign country) Maryland
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Joseph F. Day
14. MOTHER'S MAIDEN NAME Drucilla Ingalls

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No
16 SOCIAL SECURITY NO
17. INFORMANT Address Sister-Catherine May-Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) congestive failure — INTERVAL BETWEEN ONSET AND DEATH several years
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) A.S.H.D. — several mos.
DUE TO
(c)

H200

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Poss. G.U. or G.I. infection
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (this hospital) attended the deceased from 5/29/67, 1967, to 6/11, 1967, that (we) last saw the deceased alive on 6/11 1967, and that death occurred at 10:07 AM, from causes and on the date stated above

22a. SIGNATURE Marvin Wadler M.D
ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) MARVIN WADLER
22d ADDRESS 8218 Wise Av. - Bethesda Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b DATE THEREOF 6-13-67
23c NAME OF CEMETERY OR CREMATORY Goshen
23d LOCATION (City or Town) (County) (State) Goshen Mont. Md.

24. FUNERAL DIRECTOR Francis H. Barber
ADDRESS Laytonsville, Md.
25a RECD BY REGISTRAR DATE JUN 14 1967
25b. REGISTRAR'S SIGNATURE Charles Yingling

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08337 **CERTIFICATE OF DEATH** 08326

1. PLACE OF DEATH a. COUNTY: Montgomery MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland b. COUNTY:
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (rural) — c. LENGTH OF STAY IN 1b: 3 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Naval Hospital	d. STREET ADDRESS: 2216 Washington Ave. — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month Day Year
Leo	P.	DIELTZ	June 28 1967

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
Male	Cauc.	Married	Apr. 30, 1906	61 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
U. S. Navy		Pope County, Minnesota	USA

13. FATHER'S NAME: John P. Dieltz
14. MOTHER'S MAIDEN NAME: Alice Clara Clemens

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): 1924-1955
16. SOCIAL SECURITY NO: 220 34 4914
17. INFORMANT: Mrs. Pauline G. Dieltz, Address: 2216 Washington Ave., Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of the stomach
151X
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 25, 1967, to June 28, 1967, that (I) (we) last saw the deceased alive on June 28 1967, and that death occurred at 1010 PM, from causes and on the date stated above.

22a. SIGNATURE: W J Fouty M.D. ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 30 June 1967
22c. PHYSICIAN'S NAME (Type): W. J. FOUTY, M. D.
22d. ADDRESS: Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	7-3-67	Arlington National	Arlington

24. FUNERAL DIRECTOR: Robert A. Pumphrey ADDRESS: Funeral Home, 7557 Wisconsin Ave., Bethesda, Md.
25a. REC'D BY REGISTRAR DATE: JUL 6 1967
25b. REGISTRAR'S SIGNATURE: J Charles Junge

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08339 08327

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any ... is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the ... director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5. A15ME
5M 7/59

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: MARYLAND 13 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 2305 Dennis Avenue

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 2305 Dennis Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James Middle: Robert Last: Dimond

4. DATE OF DEATH: Month: June Day: 26 Year: 19 67

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 22, 1895

9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Correspondence Clerk

10b. KIND OF BUSINESS OR INDUSTRY: Dept of Army

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Thomas Dimond

14. MOTHER'S MAIDEN NAME: Margaret Mary Flynn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): None

16. SOCIAL SECURITY NO: None

17. INFORMANT: Helen M. Dimond
Address: 2305 Dennis Avenue Silver Spring, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Coronary Insufficancy Acute — INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G. Ball M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 6/26/67

EXAMINER'S NAME (Type): John G. Ball Address (Street, city, town, or county): Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: June 28, 1967
22c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cemetery
22d. LOCATION (City, town, or country) (State): Silver Spring, Maryland

23. FUNERAL DIRECTOR: C. Glen Carter C. Glen Carter
ADDRESS: 8434 Georgia Avenue Silver Spring, Md.
Warner E. Pumphrey, Inc.

24a. REG'D BY REGISTRAR DATE: JUN 30 1967
24b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 08328

08339

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: 19 days.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kensington Gardens Nursing Home.

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland. b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Kent~~ Takoma Park.
d. STREET ADDRESS: 7701 Eastern. Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3 NAME OF DECEASED (Type or print): First: Olive Middle: A. Last: Donaldson.

4 DATE OF DEATH: Month: June. Day: 25 Year: 1967

5 SEX: Fe. | 6 COLOR OR RACE: W. | 7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐ | 8 DATE OF BIRTH: 3/26/1888 | 9 AGE (In years last birthday): 79 yrs | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS: Hours, Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker
10b. KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (State or foreign country): Washington. D C
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: Fred
14 MOTHER'S MAIDEN NAME: Henrietta

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO:
17 INFORMANT: Address: Mr. Frederick DeJoseph, 5015 Brunway

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Coronary Insufficiency —
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): Cardio Vascular Disease —
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH: Days — Years

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G. Ball. M.D
EXAMINER'S NAME (Type): JOHN G. BALL
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
22. DATE SIGNED: 6/25/67

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: June 29, 1967
23c NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
23d LOCATION (City or Town) (County) (State): Prince Geo. Co. Md

24 FUNERAL DIRECTOR: J. Arthur Walters
ADDRESS: 254 Carroll St NW. Wash DC
25a RECD BY REGISTRAR DATE: JUN 30 1967
25b REGISTRAR'S SIGNATURE: J Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Film C-506 sa.

08340 [illegible] 1/13/86 CERTIFICATE OF DEATH 08329

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: D C — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 5708 Newington Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Madaline — Middle: B. — Last: Dl Donnelly

4. DATE OF DEATH: Month: June — Day: 21 — Year: 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5/31/92
9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (County & State, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOSEPH H. BYRNE
14. MOTHER'S MAIDEN NAME: ROSA L. CLINE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
16. SOCIAL SECURITY NO:
17. INFORMANT: JOHN L. DONNELLY — Address: 5708 Newington

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Rheumatic valvular disease, aortic
DUE TO (b): aortic stenosis, aortic regurgitation, mitral stenosis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Multiple pulmonary infarcts

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6/17, 1967, to 6/21, 1967 that (I) (we) last saw the deceased alive on 6/20 1967 and that death occurred at 6:24 A.M. from causes and on the date stated above

22a. SIGNATURE: Robert R. Montgomery M.D — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 6/21/67
22c. PHYSICIAN'S NAME (Type): ROBERT R. MONTGOMERY
22d. ADDRESS: 5411 CEDAR LANE BETHESDA, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE THEREOF: 6-24-1967
23c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery
23d. LOCATION (City or Town) (County) (State): Alrxandria, VA.

24. FUNERAL DIRECTOR: Joseph Gawler's Sons Inc. — ADDRESS: 5130 Wisc. Ave. N.W. Wash. D.C.
25a. REC'D BY REGISTRAR DATE: JUN 26 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, file it in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08341

CERTIFICATE OF DEATH

08330

1 PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING.
c LENGTH OF STAY IN 1b:
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 219-A. So. HAMPTON-DRIVE.

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND — b COUNTY: MONTGOMERY
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
d STREET ADDRESS: 219 A. So. HAMPTON-DR.
e IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First ELIZABETH — Middle — Last HORNBURG
4 DATE OF DEATH: Month JUNE — Day 19 — Year 1967
5 SEX: F
6 COLOR OR RACE: W
7 MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: AUG 9 1896
9 AGE (In years last birthday): 70 yrs
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE.
10b KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (County & State or foreign country): BALTIMORE MD.
12 CITIZEN OF WHAT COUNTRY? U.S.A.
13 FATHER'S NAME: JOSEPH KREUTZ
14. MOTHER'S MAIDEN NAME: GIDDS
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16 SOCIAL SECURITY NO
17 INFORMANT: RUTH MARPLE — Address 9201-N. H AVE. SILVER SPRING

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Ventricular Fibrillation — INTERVAL BETWEEN ONSET AND DEATH
4201
DUE TO
(b): Acute myocardial infarction — 4-5 hr
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertension
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a ACCIDENT WAS UNDERLYING ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that (I) (~~this hospital~~) attended the deceased from Jan, 1966, to June 19, 1967, that (I) (we) last saw the deceased alive on June 5 1967, and that death occurred at 6 A M, from causes and on the date stated above.

22a SIGNATURE: R. H. Sandstrom M.D.
M.D ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 6-19-67
22c PHYSICIAN'S NAME (Type): R. N. Sandstrom MD
22d. ADDRESS: 7701 Carroll Ave Takoma Park, Md

23a BURIAL CREMATION REMOVAL (Specify)
23b DATE THEREOF: June 21 1967
23c NAME OF CEMETERY OR CREMATORY: Rock Creek Cem.
23d LOCATION (City or Town) (County) (State): Rock Creek Rd. P. Geo Md

24 FUNERAL DIRECTOR: A. Arthur Walters
ADDRESS: 254 Eargate St. Rd.
25a RECD BY REGISTRAR DATE: JUN 21 1967
25b. REGISTRAR'S SIGNATURE: Charles Yeager

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08342 / 08331

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

1a. PLACE OF DEATH — a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross Hospital

2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) — a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 13225 Clifton Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Francis — Middle: Barrett — Last: Dorsey
4. DATE OF DEATH: Month: June — Day: 13 — Year: 19 67

5. SEX: Male
6. COLOR OR RACE: Cau
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3/16/14
9. AGE (In years last birthday): 53 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): computer programmer
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Govt.
11. BIRTHPLACE (State or foreign country): Wash., D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Francis Dorsey
14. MOTHER'S MAIDEN NAME: Catherine Barrett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service): yes Navy-WWII
16. SOCIAL SECURITY NO: 579-03-0469
17. INFORMANT: Dorothea Dorsey, wife — Address: 13225 Clifton Rd. Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Acute Coronary Insufficiency
DUE TO
(b): Coronary Artery Heart Disease
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Belden R. Reap M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): Belden R. Reap, M.D., Wheaton
Address (Street city, town or county): June 13, 1967
22. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: June 21, 1967
23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery
23d. LOCATION (City or Town) (County) (State): Washington, D. C.

24. FUNERAL DIRECTOR: Glen Carter (Glen Carter) Warner E. Pumphrey, Inc.
ADDRESS: 8434 Georgia Avenue Silver Spring, Md.
25a. RECD BY REGISTRAR: DATE JUN 21 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08343

CERTIFICATE OF DEATH

08332

1 PLACE OF DEATH
a. COUNTY: Montgomery — b. STATE: MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): University Nursing Home

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
b. STATE: Dist. of Col. — b. COUNTY:
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d STREET ADDRESS: 5415 Connecticut Ave.N.W.
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: EILEEN — Middle: ANNA — Last: DOWD

4. DATE OF DEATH: Month: JUNE — Day: 14 — Year: 19 67

5 SEX: Female
6 COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 4-3-1902
9. AGE (In years last birthday): 65 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired- Secretary
10b KIND OF BUSINESS OR INDUSTRY: N.I.H.
11 BIRTHPLACE (County & State, or foreign country): Washington, D.C.
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: Michael Dowd
14 MOTHER'S MAIDEN NAME: Mary F. Gorman

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): No. (If yes give war or dates of service): - - -
16 SOCIAL SECURITY NO: 578-08-6434
17 INFORMANT: Miss Frederica H. Dowd- Address: See Item No.2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b): Arteriosclerotic Cardiovascular disease — 10 + years
DUE TO (c): Polycythemia Vera — 10 + years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
9 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from Jan 4, 1946, to June 14, 1967, that (I) (we) last saw the deceased alive on June 12 1967, and that death occurred at 7 A M, from causes and on the date stated above

22a SIGNATURE: John E. Morris M.D — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 6/14/67
22c PHYSICIAN'S NAME (Type): JOHN E. MORRIS, M.D.
22d. ADDRESS: 1746 K St., N.W., Washington, D.C.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 6-17-1967
23c NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery
23d LOCATION (City or Town) (County) (State): Washington D C

24 FUNERAL DIRECTOR: Joseph Gawler's Sons, Inc., ADDRESS: Washington, D.C.
25a RECD BY REGISTRAR DATE: JUN 19 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

1#

FOR STATE HEALTH DEPT.

(M) 08344

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08334

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit, if pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Takoma Park, Md.
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Washington San. and Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: N.Y. — b. COUNTY
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Bronx, N.Y.
d. STREET ADDRESS: 2009 Cruger Ave. (~~2009 Cruger Ave.~~)
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

99

3 NAME OF DECEASED (Type or print) First	Middle	Last	4 DATE OF DEATH Month	Day	Year
Hyman	- None -	Dreskin	6-12-67		.9

5 SEX	6 COLOR OR RACE	7 MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8 DATE OF BIRTH	9 AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min
Male	White	MARRIED XX; NEVER MARRIED ☐; WIDOWED ☐; DIVORCED ☐	9-15-95	71 yrs		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Furier	Retired	Russia	Amer.

13 FATHER'S NAME	14 MOTHER'S MAIDEN NAME
Solomon Dreskin	Dorothy

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16 SOCIAL SECURITY NO	17 INFORMANT	Address
Yes WW I		Son (Theodore Dreskin)	1014 Osage St S.S., Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Insufficiency
DUE TO (b): Coronary Artery Heart Disease
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): BR

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work ☐ Not While at work ☐	20e PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)	20f (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Reuben Greif M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): REUBEN A. MEAD, M.D.

Address (Street or town, or county)

22. DATE SIGNED: June 12, 1967

23a BURIAL CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
burial	6/13/67	Beth El Cemetery	Emerson, New Jersey

24 FUNERAL DIRECTOR	ADDRESS	25a RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
Bernard Danzansky & Sons	3501-14th St.NW, Wash. DC	JUN 14 1967	J. Charles Jungi

VR A15ME (5)
6M 1/67

1 of 2

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08345 — 08335

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Montgomery — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
   c. LENGTH OF STAY IN 1b: 25 hours
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) — a. STATE: Maryland — b. COUNTY: ✓
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
   d. STREET ADDRESS: 1204 Jackson Ave.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles — Middle: A — Last: Durkin
4. DATE OF DEATH: Month: June — Day: 12 — Year: 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9/3/1889
9. AGE (In years last birthday): 77 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Retired Printer
10b. KIND OF BUSINESS OR INDUSTRY: Evening Star Newspaper
11. BIRTHPLACE (County & State, or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Durkin
14. MOTHER'S MAIDEN NAME: Mary Furgeson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No — None
16. SOCIAL SECURITY NO.: Yes 578-09-8715
17. INFORMANT: Esther M. Durkin — Address: 1204 Jackson Avenue Takoma Park, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): MESENTERIC ARTERY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: 30 HRS
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) MESENTERIC ARTERY ATHEROSCLEROSIS — UNKNOWN
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): CONGESTIVE HEART FAILURE, ATHEROSCLEROTIC HEART DISEASE
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from JUNE 10, 1967, to JUNE 12, 1967, that (I) (~~we~~) last saw the deceased alive on JUNE 12 1967, and that death occurred at 1:45 A.M., from causes and on the date stated above

22a. SIGNATURE: Edward A. Beeman M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: JUNE 12, 1967
22c. PHYSICIAN'S NAME (Type): EDWARD A. BEEMAN MD
22d. ADDRESS: 1015 SPRING ST SILVER SPRING, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: June 15, 1967
23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cemetery
23d. LOCATION (City or Town) (County) (State): Silver Spring, Maryland

24. FUNERAL DIRECTOR: Glen Carter, Warner E. Pumphrey, Inc. — ADDRESS: Glen Carter 8434 Georgia Avenue Silver Spring, Md.
25a. REC'D BY REGISTRAR DATE: JUN 14 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08346

CERTIFICATE OF DEATH

08336

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Germantown
d. STREET ADDRESS: #6 Flagstone Dr
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Michael — Middle: John — Last: Eader

4. DATE OF DEATH: Month: June — Day: 11 — Year: 1967

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9-23-~~66~~ 67
9. AGE (In years last birthday): 69
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Self Employed
10b. KIND OF BUSINESS OR INDUSTRY: Restaurant
11. BIRTHPLACE (County & State, or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Archie W. Eader
14. MOTHER'S MAIDEN NAME: Margaret Gardener

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
16. SOCIAL SECURITY NO (If yes give war or dates of service): no — 217-42-1598
17. INFORMANT: Address: Helen Elgin — Gaithersburg — Md (Sister)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Hepatic failure — INTERVAL BETWEEN ONSET AND DEATH: Wks
DUE TO (b): Laennec's cirhosis — years
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 5811

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Renal failure 2° to above

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year: Hour a m / p m — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 1, 1967 to June 11, 1967, that (I) (~~we~~) last saw the deceased alive on June 11, 1967, and that death occurred at 8:30 PM, from causes and on the date stated above

22a. SIGNATURE: Marvin Wadler — M.D — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 6/11/67
22c. PHYSICIAN'S NAME (Type): MARVIN WADLER
22d. ADDRESS: 8218 Wisc. Av. Beth., Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6-14-67
23c. NAME OF CEMETERY OR CREMATORY: Forest Oak
23d. LOCATION (City or Town) (County) (State): Gaithersburg Montg Md

24. FUNERAL DIRECTOR: Ernest C. Gartner — ADDRESS: Gaithersburg Md
25a. RECD BY REGISTRAR DATE: JUN 14 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08347

MEDICAL EXAMINER'S CERTIFICATE OF DEATH 18337

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg
c. LENGTH OF STAY IN 1b: 4 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 219 Cedar Ave.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg
d. STREET ADDRESS: 219 Cedar Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLES — Middle M. — Last EASTON

4. DATE OF DEATH: Month June — Day 11 — Year 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 29, 1924

9. AGE (In years last birthday): 43 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Assistant Golf Pro.

10b. KIND OF BUSINESS OR INDUSTRY: Golfing

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes — (If yes give war or dates of service) WW11

16. SOCIAL SECURITY NO. 219-03-2732

17. INFORMANT: Verna F. Easton- Item # 2 — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Insufficiency. Acute — INTERVAL BETWEEN ONSET AND DEATH: Sudden.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G. Ball M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): John G. Ball-Bethesda, Md.

Address (Street, city, town, or county):

22. DATE SIGNED: 6/12/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6/16/67

23c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery

23d. LOCATION (City, town or county) (State): Rockville, Montg. Md.

24 FUNERAL DIRECTOR: Tyson Wheeler Funeral Home

ADDRESS: 1331 Rock. Pike Rockville, Md.

25a. REC'D BY REGISTRAR DATE: JUN 15 1967

25b. REGISTRAR'S SIGNATURE: H. Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 5M 1/65

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08348 — 08338

CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 16hr-45min
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: Florida — b. COUNTY: Dade
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Miami
d. STREET ADDRESS: 6750 S.W 8th St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Charles — Middle: W — Last: Erdlitz
4. DATE OF DEATH: Month: June — Day: 21 — Year: 1967
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 18-18 ~~18~~ 88
9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrical engineer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Menomimee, Mich
12. CITIZEN OF WHAT COUNTRY? ✓
13. FATHER'S NAME: Frank Erdlitz
14. MOTHER'S MAIDEN NAME: B. Friedel
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO: 138-09-3360
17. INFORMANT: John Erdlitz — Address: Gaithersburg, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cerebrovascular accident — INTERVAL BETWEEN ONSET AND DEATH: 33 hours
DUE TO (b): Arteriosclerosis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from June 19, 1967, to June 21, 1967, that (I) ~~(we)~~ last saw the deceased alive on June 20 1967, and that death occurred at 2:15 A.M. from causes and on the date stated above

22a. SIGNATURE: Stephen C Cromwell — M.D — ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 6-21-67
22c. PHYSICIAN'S NAME (Type): Stephen C. Cromwell
22d. ADDRESS: Rockville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: June 24-67
23c. NAME OF CEMETERY OR CREMATORY: Menomimee
23d. LOCATION (City or Town) (County) (State): Mich, Menomimee Mich

24. FUNERAL DIRECTOR: Ernest C. Gartner — ADDRESS: Gaithersburg
25a. REC'D BY REGISTRAR DATE: JUN 26 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08349

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08339

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda —
c. LENGTH OF STAY IN: ~~Hospital~~ 48 min.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban.

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 100 Charles St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Raymond — Middle: Russell — Last: Etchison

4 DATE OF DEATH: Month: June — Day: 5 — Year: 1967

5 SEX: Male

6 COLOR OR RACE: White

7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: April 4-1949

9 AGE (In years last birthday): 18 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of work life even if retired): Student

10b KIND OF BUSINESS OR INDUSTRY:

BIRTHPLACE (State or foreign country): Rockville - Maryland

12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: Raymond Etchison

14 MOTHER'S MAIDEN NAME: Frances Emma Jean Smith

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 213-54-6480

17 INFORMANT: Mrs. Russell Smith — aboue (Grandparent) — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Massive intra-peritoneal hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (b): Rupture of spleen — ditto
DUE TO (c): Trauma from automobile accident — ditto

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18): Lost control of car - run off highway

20c TIME OF INJURY Month, Day, Year: 2:15 Hour pm 6/5 1967

20d INJURY OCCURRED While at work ☐ Not While at work ☒

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway

20f (City or town) (County) (State): Dorsestown-Mont. Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G. Ball M.D.
EXAMINER'S NAME (Type): John G. Ball
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):

22. DATE SIGNED: 6/6/67

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 6/9/67
23c NAME OF CEMETERY OR CREMATORY: Parklawn
23d LOCATION (City or Town) (County) (State): Rockville, Maryland

24 FUNERAL DIRECTOR: Tyson Wheeler Funeral Home
ADDRESS: 1331 Rockville Pike Rockville, Md.

25a RECD BY REGISTRAR DATE: JUN 8 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

VR ATSME (5) 6M 1/67

1 / 2

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08350 08340

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
   a. COUNTY: Montgomery — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Washington, D.C. — b. COUNTY:
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D.C.
   d. STREET ADDRESS: 1439 Rhode Island Ave.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Herbert — Middle: — Last: Fallin

4. DATE OF DEATH: Month: 6 — Day: 4 — Year: 1967

5. SEX: male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12/5/87

9. AGE (In years last birthday): 79 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: THOMAS N. FALLIN

14. MOTHER'S MAIDEN NAME: ELIZABETH S. DENTON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes give war or dates of service): WW I

16. SOCIAL SECURITY NO.: 579-60-1557

17. INFORMANT — Address: MRS CHAS. A. COURT RAINSWOOD, VA

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY
   IMMEDIATE CAUSE (a): Cerebral Vascular Damage — INTERVAL BETWEEN ONSET AND DEATH: 5 days
   DUE TO
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   (b): Cardiac arrest — 5 days
   DUE TO
   (c): acute myocardial infarction — 5 days

   PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5-31, 1967, to 6-4, 1967, that (I) (we) last saw the deceased alive on 6-4 1967, and that death occurred at 6:17 P.M., from causes and on the date stated above.

22a. SIGNATURE: Bernard Ostrow — M.O. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6-5-67

22c. PHYSICIAN'S NAME (Type): BERNARD H OSTROW

22d. ADDRESS: 8107 EASTERN AVE. S.S., Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: JUN 7, 1967

23c. NAME OF CEMETERY OR CREMATORY: MELROSE METH. CH. CEM.

23d. LOCATION (City or Town) (County) (State): LOTTSBURG, VIRGINIA

24. FUNERAL DIRECTOR: J. WM LEE & SONS

ADDRESS: 300 4½ ST. NE. WASH, DC

25a. REC'D BY REGISTRAR DATE: JUN 7 1967

25b. REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08351 08341

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission)
a. STATE: Pa. — b. COUNTY: Lehigh
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Allentown
d. STREET ADDRESS: 47 North Jefferson St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: John — Middle: Aloysius — Last: Farrell
4. DATE OF DEATH: Month: 6 — Day: 4 — Year: 1967
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12-31-1885
9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired-Engineer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State or foreign country): New Jersey
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Dennis Farrell
14. MOTHER'S MAIDEN NAME: Mary Cavanaugh

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):
16. SOCIAL SECURITY NO: 164-01-5989
17. INFORMANT: Mrs. Shelton-niece — Address: 4721 Chestnut Bethesda

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Cancer of Lung — INTERVAL BETWEEN ONSET AND DEATH:
163 x
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2 April 1967 to 4 June 1967, that (I) (we) last saw the deceased alive on 4 June 1967, and that death occurred at 3 A M, from causes and on the date stated above.

22a. SIGNATURE: A.H. Richwine MD — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐ — 22b. DATE SIGNED: 4 June 67
22c. PHYSICIAN'S NAME (Type): A.H. RICHWINE
22d. ADDRESS: 22 WESTERN AVE Chevy Chase Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6/7/67
23c. NAME OF CEMETERY OR CREMATORY: Calvary Cem.
23d. LOCATION (City or Town) (County) (State): Patterson, N.J.

24. FUNERAL DIRECTOR: Robert A. Pumphrey — ADDRESS: Bethesda, Md.
25a. REC'D BY REGISTRAR DATE: JUN 8 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08352

CERTIFICATE OF DEATH

08342

1. PLACE OF DEATH
a. COUNTY Montgomery — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda
c LENGTH OF STAY IN 1b 3 days
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Maryland

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE Maryland b. COUNTY Montgomery
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown
d. STREET ADDRESS Route #1
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First Ralph Middle Andrew Last Fetrow

4 DATE OF DEATH Month June Day 15 Year 19 67

5 SEX Male

6. COLOR OR RACE White

7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH 25 April 1954

9 AGE (In years last birthday) 13 yrs.

IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student

10b KIND OF BUSINESS OR INDUSTRY None

11. BIRTHPLACE (County & State, or foreign country) Maryland

12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME George M. Fetrow

14 MOTHER'S MAIDEN NAME Joanne Rice

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No (If yes give war or dates of service)

16. SOCIAL SECURITY NO xxxxxx

17. INFORMANT The Medical Record Address The Clinical Center, Bethesda, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1873
(b) Bronchiectasis — 2 years
DUE TO
(c) Cystic Fibrosis — since birth

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p m 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from June 12, 1967, to June 15, 1967, that ☒ (we) last saw the deceased alive on June 15 19 67, and that death occurred at 8:50 P.M., from causes and on the date stated above.

22a SIGNATURE Georges Peter M.D. ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒

22b. DATE SIGNED June 16, 1967

22c PHYSICIAN'S NAME (Type) Georges Peter, M.D.

22d ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.

23a BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE THEREOF 6/19/67

23c NAME OF CEMETERY OR CREMATORY Darnestown Church Cem.

23d LOCATION (City or Town) (County) (State) Darnestown, Md.

24 FUNERAL DIRECTOR ADDRESS Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.

25a. REC'D BY REGISTRAR DATE JUN 21 1967

25b. REGISTRAR'S SIGNATURE J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4) · 25M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08353

CERTIFICATE OF DEATH

08343

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 64 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda, Md. 20014

2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE: West Virginia — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): St. Albans
d. STREET ADDRESS: 2349 Winter Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joe — Middle: Keith — Last: Fisher

4. DATE OF DEATH: Month: June — Day: 27 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 20 December 1956

9. AGE (In years last birthday): 10 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10b. KIND OF BUSINESS OR INDUSTRY: --

11. BIRTHPLACE (County & State, or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles K. Fisher

14. MOTHER'S MAIDEN NAME: Barbara J. Currey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: The Medical Records, The Clinical Center, Bethesda, Maryland 20014 — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Septicemia, fungal — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Acute Lymphocytic Leukemia — 30 mos.
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m., 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from April 24, 1967 to June 27, 1967, that ☒ (we) last saw the deceased alive on June 27, 1967, and that death occurred at 10:20 a.m. from causes and on the date stated above.

22a. SIGNATURE: Roland T. Skeel, MD — M.D. — ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 6/27/67

22c. PHYSICIAN'S NAME (Type): Roland T. Skeel, M.D.

22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: JUNE 29, 1967

23c. NAME OF CEMETERY OR CREMATORY: Tyler mountain memorial garden

23d. LOCATION (City or Town): Charleston (County): (State): W. Va.

24. FUNERAL DIRECTOR: Robert A. Deihl — ADDRESS: Washington D.C.

25a. RECD BY REGISTRAR DATE: JUN 30 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08354 08345

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

1 PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross Hosp.

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Md
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 1412 Kanawha St
d. STREET ADDRESS: Hyattsville Md.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First — Middle — Last: Fitzpatrick

4. DATE OF DEATH: Month: 6 Day: 23 Year: 1967

5 SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6/23/1967
9. AGE (In years last birthday) yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours: 5 Min: 16

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (County & State, or foreign country): Montgomery Co, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James V. Jr.
14 MOTHER'S MAIDEN NAME: Mary Simms

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16 SOCIAL SECURITY NO
17 INFORMANT Address: James V. Fitzpatrick Jr. Hyattsville Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Pulmonary atelectasis
DUE TO
(b): Prematurity
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
7625
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6:34 P.M. 6/23, 1967, to 11:50 P.M. 6/23 67, that (I) (we) last saw the deceased alive on 6/23/ 1967, and that death occurred at 11:50 P.M. from causes and on the date stated above.

22a SIGNATURE: Joseph G. Dugan M.D. ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS ☑
22b. DATE SIGNED: 6/24/67
22c. PHYSICIAN'S NAME (Type): JOSEPH A. DUGAN, M.D.
22d. ADDRESS: 50 W. EDMONSTON DR, ROCKVILLE, MD

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6/27/67
23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven
23d. LOCATION (City or Town) (County) (State): Silver Spring, Montg. Md.

24. FUNERAL DIRECTOR: Tyson Wheeler
ADDRESS: 1331 Rockville, Pike, Rock. Md.
25a. REC'D BY REGISTRAR DATE: JUN 27 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20 M 1/66

B-276754

1

08355

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08346

CERTIFICATE OF DEATH

M

1. PLACE OF DEATH a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 16½ years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 7723 Eastern Avenue

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
d. STREET ADDRESS: 7723 Eastern Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Maud Middle: M. Last: Flagg
4. DATE OF DEATH Month: June Day: 3 Year: 1967

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Aug 22, 1870
9. AGE (In years last birthday): 96 yrs. IF UNDER 1 YEAR Months / Days; IF UNDER 24 HRS Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (County & State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John E. Miller
14. MOTHER'S MAIDEN NAME: Katherine Hager

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): None
16. SOCIAL SECURITY NO.: 213-56-0005-D1
17. INFORMANT: Burr M. Flagg Address: 7723 Eastern Ave. Takoma Park, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

420.0

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Terminal Pulmonary Edema	2 days
DUE TO (b)	Arterio-sclerotic Heart Disease	20 yrs
DUE TO (c)	Arterio-sclerosis	20 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 1/15, 1943, to 6/3, 1967, that (I) (~~we~~) last saw the deceased alive on 6/1 1967, and that death occurred at 9:15 AM, from causes and on the date stated above.

22a. SIGNATURE: Francis X Richardson M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Francis X. Richardson
22d. ADDRESS: 11412 Viers Mill Rd., Wheaton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: June 5, 1967
23c. NAME OF CEMETERY OR CREMATORY: New Norborne Cemetery
23d. LOCATION (City or Town) (County) (State): Martinsburg, W. Virginia

24. FUNERAL DIRECTOR: C. Glen Carter (C. Glen Carter) Warner E. Pumphrey, Inc. ADDRESS: 8434 Georgia Avenue Silver Spring, Md.
25a. REC'D BY REGISTRAR DATE: JUN 8 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Dr. Beldon Resp. - Mildred Edwards
Notified and certificate signed with his consent

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08356 · 08347

CERTIFICATE OF DEATH

INA M. FLORINE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 7 yrs

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Md
b. COUNTY: Prince Geo
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Langley Park
d. STREET ADDRESS: ~~8221 14th Ave~~ 8221 14th Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Montgomery Convalescent Home,

3 NAME OF DECEASED (Type or print) First	Middle	Last	4 DATE OF DEATH Month	Day	Year
Florine	—	INA M.	6	9	1967

5 SEX	6 COLOR OR RACE	7. MARITAL STATUS	8 DATE OF BIRTH	9 AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min
Female	White	MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	1-1-1885	82 yrs	6	8		

10a USUAL OCCUPATION (Give kind of work done during most of work not life, even if retired)	10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & State, or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Natural Biographie		Scotland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Alexander Munro	Mary Fornie

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17 INFORMANT Address
No		John A. Rowther, 12908 Evanston, Rockville

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Congestive Heart Failure	2wks
DUE TO (b)	Cerebrovascular Accident	Yrs
DUE TO (c)	Hypertensive C-V. Disease	Yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10/31, 1966 to 6/9, 1967, that (I) (we) last saw the deceased alive on 6/1, 1967, and that death occurred at 6:10 P.M., from causes and on the date stated above

22a SIGNATURE	M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED
C. H. Higdon		6/9/67

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
C. H. HIGDON	Sandy Spring, Md

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or town) (County) (State)
Burial	June 13, 1967	Rock Creek Cemetary	Washington D.C.

24 FUNERAL DIRECTOR	ADDRESS	25a RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
J. Arthur Walters	25 Carroll St. N.W. Washington D.C.	JUN 12 1967	J. Charles Judge

MARYLAND [illegible] ...ALTH—BALTIMORE, 18

08357

CERTIFICATE OF DEATH

08348
Reg. (Bur.) No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville

c. LENGTH OF STAY IN 1b: 1 year

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 11610 Split Rail Court

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville

d. STREET ADDRESS: 11610 Split Rail Court

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Chester — Middle: Arthur — Last: Forrest

4. DATE OF DEATH: Month: June — Day: 9 — Year: 19 67

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb 3, 1882

9. AGE (In years last birthday): 85 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: D. C. Govt.

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Leven James Forrest

14. MOTHER'S MAIDEN NAME: Lucy Callis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — If yes, give war or dates of service: None

16. SOCIAL SECURITY NO.: 577-07-6456

17. INFORMANT: W. H. Forrest — Address: 11610 Split Rail Court, Rockville, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH:

I21.0

DUE TO (b): Generalized Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 23 1967, to June 9, 1967 that I last saw the deceased alive on May 23, 1967, and that death occurred at 6:50 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: George A. Bovis M.D. — ADDRESS (Street, city or town, state): 5410 Conn. Ave., N. W., Washington, D. C. — DATE SIGNED: 6-9-67

PHYSICIAN'S NAME (Type): George A. Bovis M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: June 12 1967

22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery

22d. LOCATION (City, town, or county) (State): Suitland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Warner E. Pumphrey, Inc. — ADDRESS: 8434 Georgia Avenue, Silver Spring, Md.

24a. REC'D BY REGISTRAR DATE: JUN 14 1967

24b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15■ 9/55

Items 18-21 Film 390 7- MARYLAND STATE DEPARTMENT OF HEALTH
7-13-67 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08358 08349

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): WASH SAN + HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY: M.C.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
d. STREET ADDRESS: 7402 HANCOCK AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM Middle BRAZIER Last FRANCIS JR
4. DATE OF DEATH: Month 6 Day 4 Year 1967
5. SEX: MALE
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7-27-02
9. AGE (In years last birthday): 64 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ACCOUNTANT
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Florida
12. CITIZEN OF WHAT COUNTRY?: USA
13. FATHER'S NAME: WILLIAM BRAZIER FRANCIS SR
14. MOTHER'S MAIDEN NAME: SADIE COLTER
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT Address: PAULA LYNN FRANCIS (DAUGHTER)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Multiple skull fractures with intracranial
DUE TO
(b): hemorrhage due to fall
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last
INTERVAL BETWEEN ONSET AND DEATH:

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Deceased fell down stairs at home.
20c. TIME OF INJURY Month, Day, Year: Hour 3:15 a.m. p.m. 6-4 1967
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) Takoma Park (County) Pr.Geo. (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Belden R. Neas M.D.
EXAMINER'S NAME (Type): BELDEN R. NEAS M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street number, or rural route number, or city, or county): Takoma
22. DATE SIGNED: June 4 1967

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: June 7-1967
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
22d. LOCATION (City or Town) (County) (State): Burtsville Md. Pr.Geo. Md

24. FUNERAL DIRECTOR: Arthur Walters
ADDRESS: 254 Kennedy St
25a. RECD BY REGISTRAR DATE: JUN 6 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5)
6M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08353 Item #1d Film #G390 6/3 - 7 pc

CERTIFICATE OF DEATH

08350

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b: 8 days

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Indiana
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Indianapolis
d. STREET ADDRESS: 3015 N Meridian St.
e. RESIDENCE ON A FARM? YES ☐ NO ☐

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 7413 Birch Avenue

3 NAME OF DECEASED (Type or print): First: Frances — Middle: Elliott — Last: French

4 DATE OF DEATH: Month: June — Day: 15 — Year: 1967

5 SEX: Fem

6 COLOR OR RACE: White

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH: Feb 6 1872

9 AGE (In years last birthday): 95 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b KIND OF BUSINESS OR INDUSTRY

11 BIRTHPLACE (County & State, or foreign country): Maxwell Md

12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Montgomery Elliott

14. MOTHER'S MAIDEN NAME: Missouri Ann Garrison

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No

16 SOCIAL SECURITY NO: 213-46-7668

17. INFORMANT: Mrs Ralph E French — Address: 7413 Birch Ave Takoma Park Md

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Coronary Occ — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): Chr Deg Myocarditis + Decomp — DUE TO
(c): Years 6 Months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6/19/67, 19__ to 6/21/67, 19__ that (I) (we) last saw the deceased alive on 6/23/1967, and that death occurred at 4:05 P.M., from causes and on the date stated above.

22a SIGNATURE: Howard T Morse M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 6/25/67

22c. PHYSICIAN'S NAME (Type): Howard T Morse M.D.

22d ADDRESS: 503 Carroll Ave Takoma Park Md

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b DATE THEREOF: June 29 1967

23c. NAME OF CEMETERY OR CREMATORY: Fairfield Friends Cemetery

23d LOCATION (City or Town) (County) (State): Marion Co. Hamby Indiana

24 FUNERAL DIRECTOR: J. H. Ralph Waters — ADDRESS: 254 Carroll St N.W. D.C.

25a. REC'D BY REGISTRAR DATE: JUN 27 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

3E368 — 08351

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington San and Hosp

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: Maryland — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 1204 Lebanon St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Henry — Middle: None — Last: Friedman

4. DATE OF DEATH: Month: June — Day: 12 — Year: 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7-5-90
9. AGE (In years last birthday): 76 yrs
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Grocer
10b. KIND OF BUSINESS OR INDUSTRY: Food
11. BIRTHPLACE (County & State, or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY? Amer.

13. FATHER'S NAME: Harris Friedman
14. MOTHER'S MAIDEN NAME: Fannie Zimmerman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): Doubt
16. SOCIAL SECURITY NO.: 579-07-8977
17. INFORMANT — Address: Patient's Chart

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b): Coronary Thrombosis — 3 days
DUE TO (c): Arteriosclerotic cardio-vascular disease — Unknown
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Emphysema of lungs
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 5-30, 1967, to 6-12, 1967, that (I) (~~we~~) last saw the deceased alive on 6-12 1967, and that death occurred at 7:45 A.M., from causes and on the date stated above.

22a. SIGNATURE: Eino Magi, M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 6-12-67
22c. PHYSICIAN'S NAME (Type): EINO MAGI
22d. ADDRESS: 831 Univ. Blvd. E. Silv. Sp. Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6-13-67
23c. NAME OF CEMETERY OR CREMATORY: Natl. Mem. Park
23d. LOCATION (City or Town) (County) (State): Falls Church Va.

24. FUNERAL DIRECTOR — ADDRESS: Holberg Funeral Home 4217-9th St. N.W. D.C.
25a. RECD BY REGISTRAR DATE: JUN 14 1967
25b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of the death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08367 — 08352

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 68 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): The Clinical Center, Bethesda, Maryland

2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)
a. STATE: New Jersey
b. COUNTY: Atlantic ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pleasantville
d. STREET ADDRESS: 508 Martin Terrace
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: Henry — Last: Fuhrman

4. DATE OF DEATH: Month: June — Day: 10 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 27 April 1942

9. AGE (In years last birthday): 25 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plasterer

10b. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (County & State, or foreign country): New Jersey

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Harry W. Fuhrman

14. MOTHER'S MAIDEN NAME: Mildred Little

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): 1960-1964

16. SOCIAL SECURITY NO: 152-32-1648

17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda, Maryland 20014

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gastrointestinal hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 24 hours
DUE TO (b): Chronic myelogenous leukemia — 21 months
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): E coli and pseudomonas septicemia; cerebral edema (at post)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m., 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I (this hospital) attended the deceased from 3 April, 1967, to 10 June, 1967, that I (we) last saw the deceased alive on 10 June 19 67, and that death occurred at 9:00 M, from causes and on the date stated above.

22a. SIGNATURE: L. Kierney M.D.P. — ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS ☒

22b. DATE SIGNED: 11 June 1967

22c. PHYSICIAN'S NAME (Type): Carl Kierney, MD

22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: June 14, 1967

23c. NAME OF CEMETERY OR CREMATORY: Greenwood Cemetery

23d. LOCATION (City or Town) (County) (State): Pleasantville, New Jersey

24. FUNERAL DIRECTOR: John B. Thomas — Harner E. Pumphrey, Inc. — ADDRESS: Silver Spring, Md. 8434 Georgia Ave.

25a. RECD BY REGISTRAR DATE: JUN 14 1967

25b. REGISTRAR'S SIGNATURE: Florence Jaeger

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08362

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08353

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 1 HR 3 min
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SUBURBAN

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ROCKVILLE
d. STREET ADDRESS: 14706 CROSS WAY RD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LILIAN — Middle Krause — Last GADDIS

4. DATE OF DEATH: Month JUNE — Day 29 — Year 19 67

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8/7/06
9. AGE (In years last birthday): 60 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SEC'T-TREASURER
10b. KIND OF BUSINESS OR INDUSTRY: ARAB PEST CONTROL
11. BIRTHPLACE (State or foreign country): TEXAS
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: FRANK KRAUSE
14. MOTHER'S MAIDEN NAME: MATILDA Ohlenbrisch

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO: 465-03-9863
17. INFORMANT: Herschel Gaddis — Address: 14706 Crossway Rd. Rockville, Md.
HUSBAND of HERSHEL — SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Recent
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): Coronary Thrombosis — Recent
DUE TO
(c):

7201

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G. Ball, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): John G. Ball
Address (Street, city, town, or county): Bethesda, Md.
22. DATE SIGNED: 6/29/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Trans-Burial
23b. DATE THEREOF: July 5, 1967
23c. NAME OF CEMETERY OR CREMATORY: Moulton Cemetery
23d. LOCATION (City or Town) (County) (State): Moulton, Texas

24. FUNERAL DIRECTOR: John R. Thomas, Warner E. Pumphrey, Inc. — ADDRESS: 8434 Georgia Avenue, Silver Spring, Md.
25a. REC'D BY REGISTRAR DATE: JUL 5 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (5)
6M 1/66

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

38363

CERTIFICATE OF DEATH

08354

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 42 mins
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
d. STREET ADDRESS: 10225 Kensington Pkwy
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: JULIUS — Middle: DAVID — Last: GELLER

4. DATE OF DEATH: Month: June — Day: 26 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5/4/1914

9. AGE (In years last birthday): 53 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MANAGEMENT ANALYST

10b. KIND OF BUSINESS OR INDUSTRY: U.S.P.O. DEPT.

11. BIRTHPLACE (County & State, or foreign country): Denver, Colo

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Philip Geller

14. MOTHER'S MAIDEN NAME: Lena Kaufman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WW II

16. SOCIAL SECURITY NO: 523-09-4069

17. INFORMANT: Wife, Betty Geller — Address: Same as above

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 hour
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Coronary atherosclerosis
DUE TO
(c):
4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June, 1965, to June, 1967, that (I) (we) last saw the deceased alive on May 29 19 67, and that death occurred at 8:12 AM, from causes and on the date stated above.

22a. SIGNATURE: Emily N. Gomez, M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 26 June 1967

22c. PHYSICIAN'S NAME (Type): ORVILLE W. DONNELLY

22d. ADDRESS: 2141 K ST NW Washington DC

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 6-28-67

23c. NAME OF CEMETERY OR CREMATORY: MT. NEBO CEM.

23d. LOCATION (City or Town) (County) (State): ARAPAHOE COUNTY COLO

24. FUNERAL DIRECTOR: Goldberg Funeral Home — ADDRESS: 4217 9th ST. N.W.

25a. REC'D BY REGISTRAR DATE: JUN 28 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08364

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08355

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with n 24 hours after death. If any de ay is necessary, please execute the certificate, writing the word "pending" in pencil in Items 18 give Pages 1, 2, and 3 to the funeral director Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: D.O.A
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): R. Gaithersburg
d. STREET ADDRESS: Route #2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Other — Middle: — Last: Gentry
4 DATE OF DEATH: Month: June — Day: 8 — Year: 1967
5. SEX: M.
6. COLOR OR RACE: W.
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9/5/02
9. AGE (In years last birthday): 64 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer.
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia.
12. CITIZEN OF WHAT COUNTRY: USA.
13. FATHER'S NAME: Henry Gantry
14. MOTHER'S MAIDEN NAME: Ella. Weaver
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO: 218-20-2069
17. INFORMANT: Sister — Address: Mrs Rogers 4900 Randolph Rd. Rockville

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Injuries multiple severe — INTERVAL BETWEEN ONSET AND DEATH: instantaneous
DUE TO (b): pedestrian struck by auto
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): Walked on to highway in path of auto.
20c. TIME OF INJURY Month, Day, Year: Hour 1030 a.m. p.m. 6/8 1967
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway
20f. (City or town) (County) (State): R. Gaithersburg Mont. Md

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☐, Accident ☒ Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G. Ball M.D.
EXAMINER'S NAME (Type): John G. Ball
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
22. DATE SIGNED: 6/9/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6/12/67
23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet
23d. LOCATION (City or Town) (County) (State): McGaheysville, Virginia

24. FUNERAL DIRECTOR — ADDRESS: Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.
25a. REC'D BY REGISTRAR: JUN 15 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (5)
6M 1/67

1

Cleared with Medical Examiner
Dr. Reap 1/m R.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08365

CERTIFICATE OF DEATH

08356

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Montgomery Generah Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b COUNTY: Montgomery
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ednor Silver Spring
d STREET ADDRESS: 1106 Ednor Rd.
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Edith — Middle: ~~Amelia~~ C. — Last: George
4 DATE OF DEATH: Month: 6 — Day: 17 — Year: 1967
5 SEX: Female
6 COLOR OR RACE: White
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 11/15/~~96~~1886
9 AGE (In years last birthday): 80~~79~~ yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: -
11 BIRTHPLACE (County & State, or foreign country): Pennsylvania
12 CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Gaylord Simmons
14. MOTHER'S MAIDEN NAME: Cora Noble
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)
16 SOCIAL SECURITY NO: 578-07-4944
17 INFORMANT: Hospital Records, Olney, Maryland — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ACUTE MYOCARDIAL FAILURE — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
DUE TO (b): CHRONIC CONGESTIVE HEART FAILURE — 6 Mo
DUE TO (c): ARTERIOSCLEROTIC HEART DIS — YRS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): PULMONARY EMPHYSEMA & CHR. MALNUTRITION
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec., 1966, to 6/17, 1967, that (I) (we) last saw the deceased alive on 6/15, 1967, and that death occurred at 3:30 M, from causes and on the date stated above.

22a. SIGNATURE: Donald R. Lewis — M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 6/17/67.
22c. PHYSICIAN'S NAME (Type): Donald R. Lewis
22d. ADDRESS: Medical Center, Olney, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 6/20/67
23c NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cem.
23d LOCATION (City or Town) (County) (State): Colmar Manor, Md.
24 FUNERAL DIRECTOR: Nalley's Funeral Home Inc. — ADDRESS: Mt. Rainier Maryland
25a RECD BY REGISTRAR: JUN 21 1967
25b REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08366

CERTIFICATE OF DEATH

08359

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 1½ days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium and Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
d. STREET ADDRESS: 8505 Flower avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Marie — Middle: Elizabeth — Last: Gernand

4. DATE OF DEATH: Month: June — Day: 6 — Year: 1967

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 6-30-01

9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? America

13. FATHER'S NAME: Heinrich Humburg

14. MOTHER'S MAIDEN NAME: Katharina

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: 577-30-627-1

17. INFORMANT: Patient's chart — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Diabetic Acidosis & Coma
DUE TO (b): Acute pyelonephritis
DUE TO (c):
260 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or Town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June, 1966 to June 6, 1967 that (I) (we) last saw the deceased alive on June 5 1967, and that death occurred at 4:00 A.M. from causes and on the date stated above.

22a. SIGNATURE: Boris Rabkin MD — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: June 6, 1967

22c. PHYSICIAN'S NAME (Type): BORIS RABKIN MD

22d. ADDRESS: 1019 Univ. Blvd East

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: June 9-1967

23c. NAME OF CEMETERY OR CREMATORY: H. Lincoln

23d. LOCATION (City or Town) (County) (State): Bladensburg Rd P. Geo. Md

24. FUNERAL DIRECTOR: Arthur Walters — ADDRESS: 254 Carroll St. K

25a. REC'D BY REGISTRAR DATE: JUN 9 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08367

MEDICAL-EXAMINER'S CERTIFICATE OF DEATH

08359

1 PLACE OF DEATH
a COUNTY Montgomery — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring
c LENGTH OF STAY IN 1b D.O.A.
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE Maryland — b COUNTY Montgomery
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring
d STREET ADDRESS 10841 Childs Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First Patrick Middle Joseph Last Gibbons
4 DATE OF DEATH Month June Day 25 Year 1967
5 SEX Male
6. COLOR OR RACE White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH May 26 1930
9 AGE (In years last birthday) 37 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager
10b KIND OF BUSINESS OR INDUSTRY Owens Fiberglass Co.
11 BIRTHPLACE (State or foreign country) Ireland
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME Patrick Gibbons
14 MOTHER'S MAIDEN NAME Anna Rodgers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) Korean
16. SOCIAL SECURITY NO 578-34-7385
17. INFORMANT Mary Lou Gibbons — Address 10841 Childs Street Silver Spring, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary insufficiency — INTERVAL BETWEEN ONSET AND DEATH Acute
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) coronary arteriosclerosis
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE John G Ball M.D
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type) John G. Ball
Address (Street, city, town, or county) Bethesda, Maryland
22. DATE SIGNED 6/26/67

23a BURIAL, CREMATION, REMOVAL (Specify) Burial
23b DATE THEREOF June 28, 1967
23c NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery
23d LOCATION (City or Town) (County) (State) Silver Spring, Maryland

24 FUNERAL DIRECTOR Glen Carter — ADDRESS 8434 Georgia Avenue
Warner E. Pumphrey, Inc. Silver Spring, Md.
25a RECD BY REGISTRAR DATE JUN 28 1967
25b REGISTRAR'S SIGNATURE Charles Judge

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08368 08360

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase -
c. LENGTH OF STAY IN 1b: 6hr.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 5454 Wisconsin. Ave Barlow Bldg

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Washington — b. COUNTY: - D.C. -
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington -
d. STREET ADDRESS: 1855 Calvert St. N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Stanley — Middle: - — Last: Goldman.

4 DATE OF DEATH: Month: June — Day: 1 — Year: 1967

5 SEX: M.

6. COLOR OR RACE: W.

7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: May 11, 1931

9 AGE (In years last birthday): 36 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b KIND OF BUSINESS OR INDUSTRY

11 BIRTHPLACE (State or foreign country): Penna.

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Herman Goldman

14. MOTHER'S MAIDEN NAME: Tillie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17 INFORMANT — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carbon Monoxide Poisioning — INTERVAL BETWEEN ONSET AND DEATH: min.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.): Hose running from exhaust pipe to back window of car motor running

20c TIME OF INJURY Month, Day, Year: Hour a.m. 12 30 — 6/1/ 1967

20d INJURY OCCURRED While at work ☐ Not While at work ☒

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Office Bldg.

20f (City or town) Chevy Chase. (County) Montgomery (State)

21 I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G. Ball M.D
EXAMINER'S NAME (Type): JOHN G. BALL

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: 6/1/67

Address (Street, city, town, or county): Bethesda, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 6-3-67
23c NAME OF CEMETERY OR CREMATORY: Montefiore Cemetery
23d LOCATION (City or Town) (County) (State): Montgomery County, Pa.

24 FUNERAL DIRECTOR ADDRESS: ROBERT A. PUMPHREY, Bethesda, Maryland

25a RECD BY REGISTRAR DATE: JUN 5 1967

25b REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08363

CERTIFICATE OF DEATH

08361

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross Hosp

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MD.
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 1213 Morningside D.R.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First: ANNA Middle: Lost: Goldovsky
4 DATE OF DEATH: Month: June Day: 18 Year: 1967

5 SEX: F
6 COLOR OR RACE: Cauc.
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8 DATE OF BIRTH: 12/26/72
9 AGE (In years last birthday): 95 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (County & State, or foreign country): Russia
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: UNKNOWN
14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO: —
17. INFORMANT: Rima Greenland Address: R.D.1 Box 123 Waldorf, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebro vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 1 week
331X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from 6/8, 1967, to 6/18, 1967, that (I) ~~(we)~~ last saw the deceased alive on 6/17 1967, and that death occurred at 6:00 A.M., from causes and on the date stated above.

22a. SIGNATURE: [signature] MD ATTENDING PHYS. ☑ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 6/18/67
22c. PHYSICIAN'S NAME (Type):
22d. ADDRESS:

23a BURIAL (CREMATION) REMOVAL (Specify)
23b DATE THEREOF: 6-19-67
23c. NAME OF CEMETERY OR CREMATORY: Lee's Crematory
23d LOCATION (City or Town) (County) (State): Washington D.C.

24. FUNERAL DIRECTOR: Frazier's ADDRESS: 389 R.I. Ave. N.W. WASH, D.C.
25a REC'D BY REGISTRAR DATE: JUN 21 1967
25b. REGISTRAR'S SIGNATURE: [signature] Charles Yunger

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

28370 — 08362

PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): R. Rockville
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Woodmont Country Club.

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Washington — b. COUNTY: D.C.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington.
d. STREET ADDRESS: 2801 New Mexico Ave-N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First	Middle	Last	4 DATE OF DEATH Month	Day	Year
Ralph.	Lansburgh.	Goldsmith	June	9	1967

5 SEX	6 COLOR OR RACE	7 MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8 DATE OF BIRTH	9 AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
M.	W.	MARRIED ☒	May 2, 1895	72 yrs.		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
President Lansburgh Retired	Department Stores.	Washington D.C.	USA.

13 FATHER'S NAME	14 MOTHER'S MAIDEN NAME
Charles. Goldsmith.	Minnie Lansburgh.

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16 SOCIAL SECURITY NO	17 INFORMANT	Address
	577-01-6942	Son-in-Law. Jon. England.	1540 Rockville Pike. Rockville Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Coronary Insufficency Acute — INTERVAL BETWEEN ONSET AND DEATH: Sudden.
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 4501

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year, Hour, a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G. Ball M.D.
EXAMINER'S NAME (Type): JOHN G. BALL
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town or county)

22. DATE SIGNED: 6/9/67

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
burial	6/12/67	Wash. Heb. Cong. Cem.	Washington, D.C.

24. FUNERAL DIRECTOR: Bernard Danzansky & Sons
ADDRESS: 3501-14th St. NW, Wash. DC, 20010
RECD BY REGISTRAR: JUN 14 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08371

CERTIFICATE OF DEATH

08363

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA (RURAL)
c. LENGTH OF STAY IN 1b: 76 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): NAVAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission)
a. STATE: VIRGINIA
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ARLINGTON
d. STREET ADDRESS: 4400 LEE HIGHWAY APT. 301
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MICHAEL Middle: CHRISTOPHER Last: GOOD

4. DATE OF DEATH: Month: JUNE Day: 20 Year: 19 67

5. SEX: MALE

6. COLOR OR RACE: CAUC

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3 OCTOBER 1945

9. AGE (In years last birthday): 21 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country): FREEMONT, OHIO

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: DALE S. GOOD

14. MOTHER'S MAIDEN NAME: MARY ANN PAVELIE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)

16. SOCIAL SECURITY NO: 228-62-8650

17. INFORMANT: DALE S. GOOD, Address: 3 DENISE COURT, ST. JAMES, NEW YORK

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): WIDESPREAD METASTASIS EMBRYONAL CARCINOMA OF LEFT TESTIS WITH
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH:

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): NECROTIZING PERITONITIS SECONDARY TO INTESTIONAL STRANGULATION

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ~~(I)~~ (this hospital) attended the deceased from 5 APRIL, 19 67, to 20 JUNE, 19 67, that (I) (we) last saw the deceased alive on 20 JUNE 19 67, and that death occurred at 7:00 AM from causes and on the date stated above.

22a. SIGNATURE: Lawrence A. Jones M.D. ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 21 June 1967

22c. PHYSICIAN'S NAME (Type): Lawrence A. Jones, M. D.

22d. ADDRESS: NAVAL HOSPITAL, BETHESDA, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6/23/67

23c. NAME OF CEMETERY OR CREMATORY: NATIONAL MEMORIAL PARK

23d. LOCATION (City or Town) (County) (State): FALLS CHURCH VA.

24. FUNERAL DIRECTOR: David A. Cornell ADDRESS: ARLINGTON FUNERAL HOME, 3901 NORTH FAIRFAX DRIVE, ARLINGTON, VA.

25a. REC'D BY REGISTRAR DATE: JUN 23 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

- 1 -

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08372

CERTIFICATE OF DEATH

08364

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 26 days.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 5617 Auston Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Peter — Middle: F — Last: Gordon

4. DATE OF DEATH: Month: June — Day: 21 — Year: 19 67

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5/5-197

9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Contractor

10b. KIND OF BUSINESS OR INDUSTRY: Peter Gordon Company

11. BIRTHPLACE (County & State, or foreign country): Blackstone - Virginia

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Joseph Gordon

14. MOTHER'S MAIDEN NAME: Daniels

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): 1918 WWI

16. SOCIAL SECURITY NO: 379-12-3989A

17. INFORMANT: Mrs A. Gordon — Address: absent.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Aneurysm thoracic and abdominal aorta, ruptured — INTERVAL BETWEEN ONSET AND DEATH: 3 months
DUE TO
(b): arteriosclerosis.
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
451X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ____, 19__ to 6-21, 19 67, that (I) (we) last saw the deceased alive on 6-21 19 67, and that death occurred at 8:30 A.M., from causes and on the date stated above.

22a. SIGNATURE: A. S. Brennan — M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 6-22-67

22c. PHYSICIAN'S NAME (Type): A. S. BRENNAN

22d. ADDRESS: Chevy Chase, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6-24-67

23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven

23d. LOCATION (City or town) (County) (State): Silver Spring, Maryland

24. FUNERAL DIRECTOR: ROBERT A. PUMPHREY, Bethesda, Maryland — ADDRESS

25a. REC'D BY REGISTRAR DATE: JUN 27 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08373

CERTIFICATE OF DEATH

08365

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: D. O. A.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Holy Cross Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 510 Kerwin Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Gregory — Middle: — Last: Gouthro
4. DATE OF DEATH: Month: June — Day: 12 — Year: 19 67
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept 4, 1916
9. AGE (In years last birthday): 50 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bus Driver
10b. KIND OF BUSINESS OR INDUSTRY: Transportation
11. BIRTHPLACE (County & State, or foreign country): Novia Scotia, Canada
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: David H. Gouthro
14. MOTHER'S MAIDEN NAME: Elizabeth XXXXXXXX Mc Mullin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): None
16. SOCIAL SECURITY NO.: 579-42-1534
17. INFORMANT: Elizabeth Gouthro — Address: 510 Kerwin Road Silver Spring, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.
410
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic heart disease. — 18 mos.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from January, 1966, to June 12, 1967, that (I) ~~(we)~~ last saw the deceased alive on April 3 1967, and that death occurred at 2:31 PM, from the causes and on the date stated above.

22a. SIGNATURE: William F. Simpson M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 6/12/67
22c. PHYSICIAN'S NAME (Type): William F. Simpson, M.D. — 22d. ADDRESS: 6216 Nth. Ave NE

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: June 15, 1967 — 23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cemetery — 23d. LOCATION (City, town or county) (State): Silver Spring, Maryland

24. FUNERAL DIRECTOR: John B. Thomas for Thomas — ADDRESS: 8434 Georgia Avenue Warner E. Pumphrey, Inc. Silver Spring, Md.
25a. REC'D BY REGISTRAR DATE: JUN 15 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Juergi

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 Coroner not fied & approved

VR A15 (4)
20M 1/65

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08374

CERTIFICATE OF DEATH

08366

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 15 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium and Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
d. STREET ADDRESS: 104 Park Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Kenneth — Middle: Paul — Last: Graham

4. DATE OF DEATH: Month: June — Day: 8 — Year: 19 67

5. SEX: male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 10-6-07

9. AGE (In years last birthday): 59 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): New York

12. CITIZEN OF WHAT COUNTRY?: America

13. FATHER'S NAME: Lyman W. Graham

14. MOTHER'S MAIDEN NAME: Mabel Barbee

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT Address: Patient's chart

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Uremia — Acute severe — INTERVAL BETWEEN ONSET AND DEATH: 15 days
DUE TO
(b): Acute Renal failure. — 2 weeks
DUE TO
(c): Severe Anemia - Otherwise Etiology ?

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 293 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cerebral Palsy; Secondary Anemia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May 15, 1967, to June 7, 1967, that (I) (we) last saw the deceased alive on June 7 1967, and that death occurred at 1:45 A.M., from causes and on the date stated above.

22a. SIGNATURE: Wilford D. Meyers MD

ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: June 8, 1967

22c. PHYSICIAN'S NAME (Type): Wilford D. Meyers M.D.

22d. ADDRESS: 8323 Haddon Dr. Takoma Park Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: June 9 1967

23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery

23d. LOCATION (City or Town) (County) (State): Bladensburg Rd Md

24. FUNERAL DIRECTOR: Walter Walters — ADDRESS: 759 Eastern Ave. N.W. Washington, D.C. 20012

25a. RECD BY REGISTRAR DATE: JUN 12 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE HEALTH DEPT.

08375

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08367

1 PLACE OF DEATH
a COUNTY: Montgomery — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg
c LENGTH OF STAY IN 1b: Years
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 104 Cedar Lane

2 USUAL RESIDENCE (Where deceased lived, If institution-Residence before admission)
a. STATE: MARYLAND
b COUNTY: MONTGOMERY
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GAITHERSBURG
d STREET ADDRESS: 104 CEDAR AVENUE
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: John — Middle: ~~White~~ W. — Last: GRIFFITH

4 DATE OF DEATH: Month: June — Day: 8 — Year: 1967

5 SEX: M

6 COLOR OR RACE: W.

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: Oct 14 - 1908

9 AGE (In years last birthday): 58 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U S Goverment

10b KIND OF BUSINESS OR INDUSTRY: ////

11 BIRTHPLACE (State or foreign country): Laytonsville. Montg, Md.

12 CITIZEN OF WHAT COUNTRY? U S A

13 FATHER'S NAME: Worthington Griffith

14 MOTHER'S MAIDEN NAME: Lena Gloyd

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) WW 2

16 SOCIAL SECURITY NO: 577-28-0078

17 INFORMANT: Jane C. Griffith. As #2 — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: Days
DUE TO (b): Coronary arteriosclerosis, severe — years
Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last: DUE TO (c):

4201

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that I took charge of the remains described above held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John S. Bell M.D.
EXAMINER'S NAME (Type)
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)

22 DATE SIGNED: 6/8/67

23a BURIAL CREMATION REMOVAL (Specify): Burial
23b DATE THEREOF: 6-10-67
23c NAME OF CEMETERY OR CREMATORY: St Rose
23d LOCATION (City or Town) (County) (State): Gaithersburg. Md.

24 FUNERAL DIRECTOR: Ernest C. Gartner. — ADDRESS: Gaithersburg. Md.

25a. REC'D BY REGISTRAR DATE: JUN 12 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, the funeral director Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

VR A15ME (5)
6M 1/67

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08376 — 08368

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: 8 Month's
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Carroll Hall Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 12608 Parkland Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Emmett Middle: Russell Last: Hackworth
4. DATE OF DEATH: Month: June Day: 19 Year: 1967
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct 17, 1895
9. AGE (In years last birthday): 71 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Watch maker
10b. KIND OF BUSINESS OR INDUSTRY: Watches
11. BIRTHPLACE (County & State, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: George R. Hackworth
14. MOTHER'S MAIDEN NAME: Elizabeth Updike
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WWI
16. SOCIAL SECURITY NO.: 225-03-4605
17. INFORMANT: Emma H. Hackworth Address: 12608 Parkland Drive Rockville, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Thrombosis with left hemiplegia — INTERVAL BETWEEN ONSET AND DEATH: 4 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Multiple Cerebral Thromboses since March 1966
DUE TO (c): Cerebro-Sclerosis chronic Undetermined

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Generalized Arterio-sclerosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Nov 27, 1966 to June 19, 1967, that (I) (we) last saw the deceased alive on June 16 1967, and that death occurred at 10:25 A.M., from the causes and on the date stated above.

22a. SIGNATURE: George L Ball — ATTENDING PHYS. M.D. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: June 19, 1967
22c. PHYSICIAN'S NAME (Type): George L Ball
22d. ADDRESS: 10620 Georgia Ave Silver Spring Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: June 22, 1967
23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery
23d. LOCATION (City, town or county) (State): Prince Georges Co. Md.

24. FUNERAL DIRECTOR: John B. Thomas Warner E. Pumphrey, Inc.
ADDRESS: 8434 Georgia Avenue Silver Spring, Md.
25a. REC'D BY REGISTRAR DATE: JUN 22 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15 (4)
20M 1/65

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08377

CERTIFICATE OF DEATH

08369

1 PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HOLY CROSS HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MD. — b. COUNTY: MONTG.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
d. STREET ADDRESS: 10111 McKENNEY AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First RUSSELL — Middle E. — Last HAMILL
4. DATE OF DEATH: Month 6 — Day 24 — Year 1967

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐
8. DATE OF BIRTH: 8-12-95
9. AGE (In years last birthday): 72 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ADMINISTRATOR
10b. KIND OF BUSINESS OR INDUSTRY: VETERANS ADMIN.
11. BIRTHPLACE (County & State, or foreign country): NEW JERSEY
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JAMES HAMILL
14. MOTHER'S MAIDEN NAME: KATHERINE KILROY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): YES MAY 1917 - MAY 1919
16. SOCIAL SECURITY NO: 577-10-1041A
17. INFORMANT: MARY GENAU HAMILL — Address: 2a, b, c, d above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): acute heart failure — INTERVAL BETWEEN ONSET AND DEATH: 5 hr.
DUE TO (b): pneumonia — 5 hr
DUE TO (c): possible pulmonary infarct — 5 hr
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o m p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6/21, 1967, to 6/24, 1967, that (I) (we) last saw the deceased alive on 6/24 1967, and that death occurred at 11:30 AM, from causes and on the date stated above.

22a. SIGNATURE: Margaret Stout M.D. — ATTENDING PHYS ☒ — MED. DIRECTOR ☐ — STAFF PHYS. ☐
22b. DATE SIGNED: 6/24/67
22c. PHYSICIAN'S NAME (Type): HENRY W. STOUT
22d. ADDRESS: 10011 GEORGIA AVE SILVER SPRING MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 27 JUNE 1967
23c. NAME OF CEMETERY OR CREMATORY: MT. OLIVET CEMETERY
23d. LOCATION (City or Town) (County) (State): WASHINGTON DC.

24. FUNERAL DIRECTOR: LINARDI FUNERAL HOME — ADDRESS: 7100 GEORGIA AVE. NW DC 20012
25a. RECD BY REGISTRAR DATE: JUN 27 1967
25b. REGISTRAR'S SIGNATURE: [illegible] Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08378

CERTIFICATE OF DEATH

08370

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 61 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Naval Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: North Carolina
b. COUNTY: Robeson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fairmont
d. STREET ADDRESS: Rural Route 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First Daniel — Middle Monroe — Last HARDIN

4. DATE OF DEATH: Month June — Day 06 — Year 1967

5 SEX: Male

6 COLOR OR RACE: Caucc

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐

8 DATE OF BIRTH: Sept 8, 1890

9 AGE (In years last birthday): 76 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b KIND OF BUSINESS OR INDUSTRY

11 BIRTHPLACE (County & State, or foreign country): Fairmont, N.C.

12 CITIZEN OF WHAT COUNTRY? U.S.

13 FATHER'S NAME: Everett Hardin

14 MOTHER'S MAIDEN NAME: Catherine Graham

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service)

16 SOCIAL SECURITY NO.

17. INFORMANT — Address: Billy E. Hardin, R.R.2, Fairmont, N.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Septicemia — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
1910
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Carcinomatosis
DUE TO transitional cell carcinoma of the bladder
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from 5 April, 1967, to 6 June, 1967, that ☒ (we) last saw the deceased alive on 6 June 1967, and that death occurred at 2:10 A.M., from causes and on the date stated above

22a SIGNATURE: James L Snyder, MD — ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS ☒

22b. DATE SIGNED: 6 June 1967

22c PHYSICIAN'S NAME (Type): James L. Snyder, LCDR MC USN

22d ADDRESS: Naval Hospital, Bethesda, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE THEREOF: 6/6/67

23c NAME OF CEMETERY OR CREMATORY: Bethesda

23d. LOCATION (City or Town) (County) (State): Barnesville, North Carolina

24. FUNERAL DIRECTOR: R.M. Jackson — ADDRESS: 472 N. Washington Street, Pearsons Funeral Home, Falls Church, Virginia

25a REC'D BY REGISTRAR: DATE JUN 12 1967

25b REGISTRAR'S SIGNATURE: J Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08373 08371

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/68

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Fairland Nursing Home

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 432 Rosecroft Terr.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Mary — Middle: Anna — Last: Harmis

4 DATE OF DEATH: Month: 6 — Day: 22 — Year: 1967

5 SEX: female

6. COLOR OR RACE: White

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 4-28-1874

9. AGE (In years last birthday): 93 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11 BIRTHPLACE (County & State, or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Andrew-Nazaranus

14. MOTHER'S MAIDEN NAME: Louise Stevens

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown). (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.: UNKNOWN

17 INFORMANT: GEORGE W. WEISS — Address: 11623 34th Place, Beltsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 6-8 hrs
DUE TO (b): Congestive heart failure — 6-8 hrs
DUE TO (c): arteriosclerotic heart disease — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): (1) Urinary tract infection (2) Anemia-mild

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from 12-14, 1965 to 6-22, 1967 that (I) (we) last saw the deceased alive on 6-21 1967, and that death occurred at 1:15 P.M., from causes and on the date stated above.

22a. SIGNATURE: John R. Spencer — M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6-22-67

22c. PHYSICIAN'S NAME (Type): JOHN R. SPENCER

22d. ADDRESS: BURTONSVILLE, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 6-24-1967

23c. NAME OF CEMETERY OR CREMATORY: LAUREL PARK CEM.

23d. LOCATION (City or Town) (County) (State): BALTIMORE MARYLAND

24. FUNERAL DIRECTOR — ADDRESS: W. W. Chambers & Rinaldi, Md.

25a. REC'D BY REGISTRAR — DATE: JUN 23 1967

25b. REGISTRAR'S SIGNATURE: [illegible] Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08380 08372

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Rockville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 10735 Hunting Lane

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Rockville
d. STREET ADDRESS: 10735 Hunting Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Henry — Middle: W. — Last: Harmon
4. DATE OF DEATH: Month: June — Day: 19, — Year: 19 67

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 20, 1904
9. AGE (In years last birthday): 63 YRS
IF UNDER 1 YEAR: Months: 0 Days: 29 — IF UNDER 24 HRS: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Harmon
14. MOTHER'S MAIDEN NAME: Mollie Butt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes give war or dates of service): WWII
16. SOCIAL SECURITY NO.: 212-14-6629
17. INFORMANT — Address: Preston Butt- Hunting Hill, Md.(

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 2 months
DUE TO (b): anemia — 6 months
DUE TO (c): Possible malignancy, not confirmed at — ?
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
194.2

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): V.A. Hospital Bay 1967.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (1) (this hospital) attended the deceased from 1963, 19, to June 19, 1967, that (I) (we) last saw the deceased alive on June 13 1967, and that death occurred at 6 A.M., from causes and on the date stated above.

22a. SIGNATURE: W.A. Linthicum — M.D — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 6/19/67.
22c. PHYSICIAN'S NAME (Type): William Linthicum
22d. ADDRESS: 110 S. Washington St., Rockville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6/22/67
23c. NAME OF CEMETERY OR CREMATORY: Rockville Cemetery
23d. LOCATION (City or Town) (County) (State): Rockville, Montg. Md.

24. FUNERAL DIRECTOR: Tyson Wheeler — ADDRESS: 1391 Rockville Pike Rockville, Maryland
25a. REC'D BY REGISTRAR: JUN 23 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08382

CERTIFICATE OF DEATH

08374

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 4504 Maple Avenue

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 4504 Maple Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FLORENCE — Middle E. — Last HARRIS

4. DATE OF DEATH: Month June — Day 1, — Year 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 26, 1885

9. AGE (In years last birthday): 81 yrs

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Charles Townsend Harris

14. MOTHER'S MAIDEN NAME: Caroline Bronski

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO:

17. INFORMANT: Cousin — Address: 2039 N.H.Ave,N.W. Washington, D. C.
Mrs. Earl P. Clark

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Acute coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs
DUE TO (b): Arteriosclerotic heart disease — 8 yrs
DUE TO (c):
4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertensive Cardiovascular disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from August, 19 57 to June 1, 1967, that (I) (we) last saw the deceased alive on March 27 1967, and that death occurred at 9 50 A.M., from causes and on the date stated above.

22a. SIGNATURE: Robert N. Coale — M.D. ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 6-1-67

22c. PHYSICIAN'S NAME (Type): ROBERT N. COALE

22d. ADDRESS: 4429 Bradley Lane Bethesda, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Crematory

23b. DATE THEREOF: 6-2-67

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory

23d. LOCATION (City or Town) (County) (State): Suitland, Maryland

24. FUNERAL DIRECTOR ADDRESS: ROBERT A. PUMPHREY, Bethesda, Maryland

25a. RECD BY REGISTRAR DATE: JUN 5 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1 4

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08381 08373

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b: 8 Months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 14710 New Hampshire Ave.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING Md.
d. STREET ADDRESS: 14710 NEW HAMP. AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ELSIE — Middle MAY — Last HARRISS

4. DATE OF DEATH: Month 6 — Day 12 — Year 1967

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 7/20/1897

9. AGE (In years last birthday): 69 yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if ret red): HOUSE KEEPING.

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (County & State, or foreign country): POTOMAC, MONT. Co MD.

12. CITIZEN OF WHAT COUNTRY?: USA.

13. FATHER'S NAME: JOSEPH WINSOR

14. MOTHER'S MAIDEN NAME: ODIE HALL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): —

16. SOCIAL SECURITY NO.:

17. INFORMANT: DAUGHTER (O. COLLINS) — Address: SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): ACUTE MYOCARDIAL DISEASE — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): ARTERIOSCLEROTIC HYPERTENSIVE HEART DIS — Yes.
DUE TO (c): GENERALIZED ARTERIOSCLEROSIS — Yes.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from January, 1967, to 6/12, 1967, that (I) (we) last saw the deceased alive on May 19 1967, and that death occurred at 6:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Donald R. Lewis MD — M.D. — ATTENDING PHYS. ☒ — MED. DIRECTOR ☐ — STAFF PHYS. ☐

22b. DATE SIGNED: 6/12/67

22c. PHYSICIAN'S NAME (Type): DONALD R. LEWIS

22d. ADDRESS: 700 CLOVERLY ST. SILVER SPRING, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6-15-67

23c. NAME OF CEMETERY OR CREMATORY: Potomac Meth. Ch. Cem.

23d. LOCATION (City, town or county) (State): Potomac, Maryland

24. FUNERAL DIRECTOR — **ADDRESS**: ROBERT A. PUMPHREY, Bethesda, Maryland

25a. REC'D BY REGISTRAR — DATE: NOV 16 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08383

CERTIFICATE OF DEATH

08375

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A11 (4)
20 M 1/66

1 PLACE OF DEATH
a. COUNTY: MONTGOMERY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL BETHESDA
c. LENGTH OF STAY IN 1b: 35 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): NAVAL HOSPITAL, BETHESDA, MD. 20014

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: WASHINGTON, D. C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town):
d. STREET ADDRESS: 1530 29th ST. N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FRANKLIN Middle A. Last HART
4. DATE OF DEATH: Month 22 JUNE Day Year 1967
5. SEX: MALE
6. COLOR OR RACE: CAUCASIAN
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 16 SEPT 1894
9. AGE (In years last birthday): 72 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MILITARY
10b. KIND OF BUSINESS OR INDUSTRY: USMC
11. BIRTHPLACE (County & State, or foreign country): CUTHBERT, GEORGIA
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: SAMUEL BEALL HART
14. MOTHER'S MAIDEN NAME: FLORENCE SMITH
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes give war or dates of service): WW I & II
16. SOCIAL SECURITY NO.: 578-52-4656
17. INFORMANT: KATHERINE HART Address: 1530 29th ST N.W., W,D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): EMPHYSEMA
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 15 YRS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I (this hospital) attended the deceased from 19 MAY, 1967, to 22 JUNE, 1967, that I (we) last saw the deceased alive on 22 JUNE 1967, and that death occurred at 1:20 PM, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 22 JUNE 1967
22c. PHYSICIAN'S NAME (Type): F. H. O'CONNELL CDR MC USN
22d. ADDRESS: NAVAL HOSPITAL, BETHESDA, MD 20014

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 6-26-1967
23c. NAME OF CEMETERY OR CREMATORY: ARLINGTON NAT'L
23d. LOCATION (City or Town) (County) (State): ARLINGTON, ARLINGTON, VA.

24. FUNERAL DIRECTOR: JOS. GAWLER & SONS ADDRESS: WASHINGTON, D.C.
25a. REC'D BY REGISTRAR DATE: JUN 29 1967
25b. REGISTRAR'S SIGNATURE: [signature]

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08384

CERTIFICATE OF DEATH

08377

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c LENGTH OF STAY IN 1b: 5 days
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HOLY CROSS HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a STATE: MARYLAND
b COUNTY: MONTGOMERY
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
d STREET ADDRESS: 8722 COLESVILLE RD.
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: RITA — Middle: M — Last: HENKELS
4. DATE OF DEATH: Month: JUNE — Day: 7 — Year: 1967

5 SEX: F
6 COLOR OR RACE: W
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 3/16/1901
9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired clerk
10b KIND OF BUSINESS OR INDUSTRY: U.S. Govt.
11 BIRTHPLACE (County & State, or foreign country): IOWA
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Paul Henkels
14. MOTHER'S MAIDEN NAME: Elizabeth Pins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): None
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Abbie V. Henkels — Address: 8722 Colesville Road, Silver Spring, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease Minfarct
DUE TO (b): 1) acute myocardial infarction (?)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): 2) myocardial fibrosis
3) coronary atherosclerosis
INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pulmonary Tuberculosis
19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from MARCH 10, 1967, to JUNE 7, 1967, that (I) (we) last saw the deceased alive on JUNE 7 1967, and that death occurred at 7:10 A.M., from causes and on the date stated above

22a. SIGNATURE: Edward G. Bellman M.D. — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b DATE SIGNED: JUNE 7, 1967
22c. PHYSICIAN'S NAME (Type): EDUARD A. BELLMAN M.D.
22d. ADDRESS: 1015 SPRING ST, SILVER SPRING, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: June 10, 1967
23c NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cemetery
23d. LOCATION (City or Town) (County) (State): Silver Spring, Maryland

24. FUNERAL DIRECTOR: Glen Carter, Warner E. Pumphrey, Inc. — ADDRESS: 8134 Georgia Avenue, Silver Spring, Md.
25a. REC'D BY REGISTRAR DATE: JUN 12 1967
25b REGISTRAR'S SIGNATURE: Florida Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08385

CERTIFICATE OF DEATH

08378

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 14 hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda, Md. 20014

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: District of Columbia
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 1956 Fendall Street, S.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Stanley — Middle: Franklin — Last: Henry

4 DATE OF DEATH: Month: June — Day: 20 — Year: 19 67

5 SEX: Male

6 COLOR OR RACE: White

7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 1 April 1954

9 AGE (In years last birthday): 13 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10b. KIND OF BUSINESS OR INDUSTRY: None

11 BIRTHPLACE (County & State, or foreign country): North Carolina

12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: George Henry

14 MOTHER'S MAIDEN NAME: Mary Fennell

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service)

16 SOCIAL SECURITY NO: None

17 INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Pulmonary Edema & Ventricular Fibrillation	1 hour
DUE TO		
(b)	Cardiomegaly	6 months
DUE TO		
(c)	Muscular Dystrophy vs. Polymyositis	13 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. **I certify** that ☒ (this hospital) attended the deceased from 19 June, 1967, to 20 June, 1967, that ☒ (we) last saw the deceased alive on 20 June 1967, and that death occurred at 2:25 A.M. from causes and on the date stated above.

22a SIGNATURE: Robert C. Griggs M.D. — ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒

22b DATE SIGNED: 20 June 1967

22c PHYSICIAN'S NAME (Type): Robert C. Griggs, M.D.

22d ADDRESS: The Clinical Center, National Institutes of Health, Bethesda, Md.

23a BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF: 6/24/67

23c NAME OF CEMETERY OR CREMATORY: Leatherman Cemetary

23d LOCATION (City or Town): Harrell, (County): (State): N.C.

24 FUNERAL DIRECTOR: Montgomery Bros Inc. — ADDRESS: 719 Kennedy St NW

25a RECEIVED BY REGISTRAR DATE: JUN 26 1967

25b REGISTRAR'S SIGNATURE: J. Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08386

CERTIFICATE OF DEATH

08379

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 7 days
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda, Md. 20014

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b COUNTY: Washington
c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 1900 Virginia Avenue
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

25

3 NAME OF DECEASED (Type or print): First: Jo Ann — Middle: Lee — Last: Hess

4. DATE OF DEATH: Month: June — Day: 15 — Year: 19 67

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 26, 1932
9. AGE (In years last birthday): 34 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b KIND OF BUSINESS OR INDUSTRY: ---
11 BIRTHPLACE (County & State, or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Robert Gilbert
14 MOTHER'S MAIDEN NAME: Alice Wood

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes give war or dates of service)
16 SOCIAL SECURITY NO.: 217-28-7139
17. INFORMANT: The Medical Records, Address: The Clinical Center, Bethesda, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Increased Intracranial pressure — INTERVAL BETWEEN ONSET AND DEATH: 6 Weeks
1909
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Intracerebral metastasis — 6 Weeks
DUE TO
(c): Malignant Melanoma — 15 Months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 8, 19 67, to June 15, 1967, that (I) (we) last saw the deceased alive on June 15, 19 67, and that death occurred at 2:25 AM, from causes and on the date stated above.

22a. SIGNATURE: Vincent T. DeVita
M.D ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS ☒
22b. DATE SIGNED: 15 June 1967
22c PHYSICIAN'S NAME (Type): Vincent T. DeVita, Jr. MD.
22d ADDRESS: The Clinical Center, National Institutes of Health, Bethesda, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b DATE THEREOF: 6/17/67
23c NAME OF CEMETERY OR CREMATORY: CEDAR LAWN MEMORIAL PARK
23d. LOCATION (City or Town) (County) (State): HAGERSTOWN, WASH.CO. MD.

24. FUNERAL DIRECTOR ADDRESS: CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.
25a RECD BY REGISTRAR DATE: JUN 20 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

BR

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08387

CERTIFICATE OF DEATH

08330

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 1 Day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Naval Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 5813 Green Tree Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edgar — Middle: Flanoy — Last: Hicks Jr.

4. DATE OF DEATH: Month: June — Day: 11 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: Cauc

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 7 1907

9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineering

10b. KIND OF BUSINESS OR INDUSTRY: Ch./Eng.

11. BIRTHPLACE (County & State, or foreign country): Jackson, Tennessee

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edgar Flanoy Hicks Sr.

14. MOTHER'S MAIDEN NAME: Willie Jackson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes give war or dates of service): W. W. II

16. SOCIAL SECURITY NO: 535 36 1363

17. INFORMANT: Jean R. Hicks — Address: 5813 Green Tree Rd. Bethesda, maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infraction, Acute — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10 June, 1967, to 11 June, 1967, that (I) (we) last saw the deceased alive on 11 June 1967, and that death occurred at 1026a M, from causes and on the date stated above.

22a. SIGNATURE: Jack E. Zimmerman M.D. — ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 12 June 1967

22c. PHYSICIAN'S NAME (Type): Jack E. Zimmerman M. D.

22d. ADDRESS: Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6/15/67

23c. NAME OF CEMETERY OR CREMATORY: Baltimore National Cemetery, Baltimore, Maryland

23d. LOCATION (City or Town) (County) (State)

24. FUNERAL DIRECTOR: Jos. Gawler & Sons — ADDRESS: 5130 Wisconsin Ave., N.W., Washington, D.C.

25a. REC'D BY REGISTRAR: JUN 19 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20 M 1/66

Items 18-21 Film 390 7-12

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08388

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08381

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE: Maryland b. COUNTY: Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney c. LENGTH OF STAY IN 1b: D. O. A.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Catonsville 12-2
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Montgomery General Hospital	d. STREET ADDRESS: 132 Newburg Ave. e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Clara	Catherine	Hill	6	28	19 67

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min
Female	White	MARRIED ☒	2/3/13	54 yrs		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
CLERK, JOHNS HOPKINS		Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
JOHN HOLSEY	ROSE SCHINDLE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
		ARTHUR E HILL

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Rupture of heart	Sudden
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	crushed chest	Sudden
DUE TO		
(c)	trauma from auto accident	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Barbiturate sedation

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
	Ran car off road and struck utility pole				
20c. TIME OF INJURY Month, Day, Year: 5 10 Hour a.m. p.m. 28 June 67	20d. INJURY OCCURRED While at work ☐ Not While at work ☒	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway	20f. (City or town): Olney	(County): Montgomery	(State): Md

21. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G. Ball M.D.

EXAMINER'S NAME (Type)

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

22. DATE SIGNED: 6/29/67.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
BURIAL	7/3/67	BALTIMORE NATIONAL	BALTO.		MD.

24. FUNERAL DIRECTOR	ADDRESS	25a. RECD BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
E. S. MACNABB	301 FREDERICK 21223	DATE JUL 3 1967	Charles Judge

VR A15ME(S) 6M 1/66

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08389 08382

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Damascus
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 26134 Ridge Rd.

2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Damascus
d. STREET ADDRESS: 26134 Ridge Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Grover — Middle: -- — Last: Hilton

4. DATE OF DEATH: Month: June — Day: 5 — Year: 19 67

5 SEX	6 COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9 AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min
Male	White	NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	Jan. 12, 1886	81 yrs		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Farmer	Own farm	Damascus, Md.	USA

13. FATHER'S NAME: John Brice Hilton

14. MOTHER'S MAIDEN NAME: Sarah Elizabeth Brown

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	217-30-2293	Ernest G. Hilton, Damascus, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY.

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Multiple Cerebral Thrombi	
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Advanced Arteriosclerotic Cardio-Vascular	10 years
DUE TO (c)	Disease.	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town)	(County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1957, 19___, to June 5, 1967, that (I) (We) last saw the deceased alive on June 5, 1967 and that death occurred at 6 P M, from causes and on the date stated above.

22a. SIGNATURE: M. McKendree Boyer M.D — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: June 6, 1967

22c. PHYSICIAN'S NAME (Type): M. McKendree Boyer, M. D.

22d. ADDRESS: 9701 Church Street Damascus, Maryland.

23a BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	June 8, 1967	Damascus Meth.	Damascus, Md.

24 FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Olin L. Molesworth, Damascus, Md.	JUN 12 1967	Charles Judge

1

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08383

28390

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH
a COUNTY: MONTGOMERY — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c LENGTH OF STAY IN: 2days/20½ hr.
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE: Maryland — b COUNTY: Montgomery
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 1005 Hobbs Dr.
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Piper — Last: Hollcroft

4. DATE OF DEATH: Month: June — Day: 26, — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-9-86

9. AGE (In years last birthday): 80 yrs
IF UNDER 1 YEAR: Months / Days / Hours / Min
UNDER 24 HRS

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired - Teacher

10b. KIND OF BUSINESS OR INDUSTRY: - - -

11. BIRTHPLACE (State or foreign country): Ky.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Augustus Piper

14. MOTHER'S MAIDEN NAME: Lucy Hammond

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): - - -

16. SOCIAL SECURITY NO: - - - -

17. INFORMANT: Hospital Records — Address: 7600 Carroll Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: days
DUE TO (b): Generalized Arteriosclerosis — years
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
H500

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fracture of Left wrist -

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.): Fell on left arm

20c. TIME OF INJURY Month, Day, Year: Hour a.m. / p.m. 7 — June 13 19 67

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm factory, street, office bldg. etc.): Home -

20f. (City or town) Union Springs. (County) (State) Ky.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John S. Bell. M.D

EXAMINER'S NAME (Type)

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

22. DATE SIGNED: 6/26/67

23a. BURIAL CREMATION, REMOVAL (Specify): Removal

23b. DATE THEREOF: 6-27-1967

23c. NAME OF CEMETERY OR CREMATORY: Oak Glen Cemetery

23d. LOCATION (City or Town) (County) (State): Aurora N.Y.

24. FUNERAL DIRECTOR: Joseph Gawler's Sons, Inc. — ADDRESS: 5130 Wisc. Ave. N.W. Wash. DC.

25a. RECD BY REGISTRAR DATE: JUN 29 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

1 6

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #2d Film #3390 5/24/67 pc

CERTIFICATE OF DEATH

08391 08384

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1 PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney c. LENGTH OF STAY IN 1b: 9 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Montgomery General Hospital	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland — b. COUNTY: Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney d. STREET ADDRESS: c/o Gordon Ulmstead - Son e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First: Bertha	Middle: Alice	Last: Holt	4. DATE OF DEATH	Month: 6	Day: 9	Year: 19 67	
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH: 12/29/86	9. AGE (In years last birthday): 80 yrs	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country): Washington, D. C.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Joseph King		14. MOTHER'S MAIDEN NAME: Nancy Parsley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No	16. SOCIAL SECURITY NO.: 215-13-6230	17. INFORMANT: Hospital Records, Address: Olney, Maryland	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY.

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Uremia	2 yrs.
DUE TO (b)	Chronic pyelonephritis	10 yrs.
DUE TO (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 6-2-67, 19__, to 6-9-67 19__, that (I) (we) last saw the deceased alive on 6-9-67 19__, and that death occurred at 9 P M, from causes and on the date stated above.

22a. SIGNATURE: Frederick Moomau MD	ATTENDING PHYS ☐	MED DIRECTOR ☐	STAFF PHYS ☐	22b. DATE SIGNED: 6-10-67	
22c. PHYSICIAN'S NAME (Type): FREDERICK MOOMAU	22d. ADDRESS: Sandy Spring, Maryland				

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE THEREOF: 6-12-67	23c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery	23d. LOCATION (City or Town) (County) (State): Rockville, Maryland	
24. FUNERAL DIRECTOR: Robert A. Pumphrey,	ADDRESS: Bethesda, Maryland	25a. REC'D BY REGISTRAR: JUN 16 1967	25b. REGISTRAR'S SIGNATURE: J. Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08392

CERTIFICATE OF DEATH

08385

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OLNEY
c. LENGTH OF STAY IN 1b: 2 DAYS

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GAITHERSBURG 151
d. STREET ADDRESS: Box 192, Route 2
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MONTGOMERY GENERAL HOSPITAL

3. NAME OF DECEASED (Type or print): First GEORGE Middle WASHINGTON Last HOWES

4. DATE OF DEATH: Month 6 Day 21 Year 19 67

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 2-28-91

9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10b. KIND OF BUSINESS OR INDUSTRY: FARMING

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JAMES R. HOWES

14. MOTHER'S MAIDEN NAME: ELIZA GREEN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 217 32 3586

17. INFORMANT: MEDICAL RECORD DEPT. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Congestive Heart Failure (Acute & Chronic)
DUE TO (b): ① A.H.D. ② Aplastic Anemia (Reversal of
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Polycythemia Vera)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1950, 19__ to _____, 19__, that (I) (we) last saw the deceased alive on 6-21-1967, and that death occurred at 2:10 PM, from causes and on the date stated above.

22a. SIGNATURE: Jack Schumacher M.D. — ATTENDING PHYS [ ] MED DIRECTOR [X] STAFF PHYS [ ]

22b. DATE SIGNED: 6-23-67

22c. PHYSICIAN'S NAME (Type): JACK SCHUMACHER, M. D.

22d. ADDRESS: GAITHERSBURG, MD.

23a. BURIAL CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: June 23 1967

23c. NAME OF CEMETERY OR CREMATORY: Laytonsville

23d. LOCATION (City or Town) (County) (State): Laytonsville Mont. Md.

24. FUNERAL DIRECTOR: Francis H. Barber — ADDRESS: Laytonsville Md.

25a. REC'D BY REGISTRAR DATE: JUN 28 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08393

CERTIFICATE OF DEATH

08388

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA, RURAL
c. LENGTH OF STAY IN 1b: 67
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): US NAVAL

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND — b. COUNTY: 7
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PORT DEPOSIT
d. STREET ADDRESS: RT#1, BOX 210
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: OLIVER — Middle: (NMN) — Last: HUDSON

4. DATE OF DEATH: Month: JUNE — Day: 2 — Year: 1967

5. SEX: MALE

6. COLOR OR RACE: NEGRO

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JUNE 10 1916

9. AGE (In years last birthday): 50 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S. NAVY

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country):

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES
(If yes give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: ANNA MEAUX — Address: 423 ASH STREET LEXINGTON, KY.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): HODGKIN'S DISEASE
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MED CAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a m p m 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm factory street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from MARCH 27, 1967, to JUNE 2, 1967, that (I) (we) last saw the deceased alive on JUNE 2 1967, and that death occurred at 4:35 AM from causes and on the date stated above.

22a. SIGNATURE: J. E. ZIMMERMAN — J. E. Zimmerman — M.D. ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒

22b. DATE SIGNED: JUNE 3 1967

22c. PHYSICIAN'S NAME (Type):

22d. ADDRESS: US NAVAL HOSPITAL, BETHESDA, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 6-6-67

23c. NAME OF CEMETERY OR CREMATORY: HILLDALE CEMETERY

23d. LOCATION (City or Town) (County) (State): DANVILLE KY.

24. FUNERAL DIRECTOR: R. A. PUMPHREY FUNERAL HOME
ADDRESS: 7557 WISCONSIN AVE BETHESDA, MD

25. LOCAL REGISTRAR: DATE JUN 8 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, with in 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08394

CERTIFICATE OF DEATH

08387

1 PLACE OF DEATH
a COUNTY: Montgomery — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c LENGTH OF STAY IN 1b: 33 days
d NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): The Clinical Center, Bethesda, Maryland

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE: Pennsylvania
b COUNTY:
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cresson
d STREET ADDRESS: 893 William Penn Highway
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Thomas — Middle: Alfred — Last: Hufford

4 DATE OF DEATH: Month: June — Day: 6 — Year: 19 67

5 SEX: Male

6 COLOR OR RACE: White

7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 21 August 1948

9. AGE (In years last birthday): 18 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10b KIND OF BUSINESS OR INDUSTRY: None

11 BIRTHPLACE (County & State, or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Raymond P. Hufford

14. MOTHER'S MAIDEN NAME: Virginia Earhert

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):

16 SOCIAL SECURITY NO: None

17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 5 Days
DUE TO
(b): Hodgkin's Disease — 9 Years
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

201X

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pancytopenia

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from 2 May, 1967 to 6 June, 1967, that ☒ (we) last saw the deceased alive on 6 June 19 67, and that death occurred at 11:05 A.M., from causes and on the date stated above

22a SIGNATURE: Jerry L. Spivak M.D. — ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒

22b DATE SIGNED: June 6, 1967

22c PHYSICIAN'S NAME (Type): Jerry L. Spivak, M. D.

22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 6/10/67

23c NAME OF CEMETERY OR CREMATORY: St. Aloysius

23d LOCATION (City or Town) (County) (State): Cresson, Cambrice Co., Pa.

24 FUNERAL DIRECTOR: Tyson Wheeler Funeral Home — ADDRESS: 1331 Rockville Pike, Rockville, Maryland

25a RECD BY REGISTRAR DATE: JUN 8 1967

25b REGISTRAR'S SIGNATURE: J. Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

38393 — 08388

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND	2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE: Maryland — b. COUNTY: Charles
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (rural) — c LENGTH OF STAY IN 1b: 6 days	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Indian Head
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Naval Hospital	d. STREET ADDRESS: 1007 Kenneth Street — e IS RESIDENCE ON A FARM? YES ☐ NO ☒
3 NAME OF DECEASED (Type or print): First: Jon — Middle: Hudson — Last: HULME	4. DATE OF DEATH: Month: June — Day: 13 — Year: 19 67
5 SEX: Male — 6. COLOR OR RACE: Cauc. — 7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8 DATE OF BIRTH: July 1, 1920 — 9. AGE (In years last birthday): 46 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): USAF Ret. — 10b KIND OF BUSINESS OR INDUSTRY: Major — 11 BIRTHPLACE (County & State, or foreign country): Atlanta, Georgia — 12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: John Henry Hulme — 14 MOTHER'S MAIDEN NAME: Jimmie Liela Upchurch	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): 1941-1965 — 16. SOCIAL SECURITY NO: 259-03-4660 — 17. INFORMANT: S.W., Atlanta — Address: Georgia Mrs. Lanett D. Hulme, 335 Wellington St.	

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c))
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Esoph · Esophageal varices Laennec's Cirrhosis — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED White at work ☐ Not White at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 7, 1967, to June 13, 1967, that (I) (we) last saw the deceased alive on June 13, 19 67, and that death occurred at 625 AM, from causes and on the date stated above

22a SIGNATURE: W. J. Douty, M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ — 22b. DATE SIGNED: 14 June 1967

22c. PHYSICIAN'S NAME (Type): W. J. DOUTY, CDR MC USN — 22d ADDRESS: Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b DATE THEREOF: 6/16/1967	23c. NAME OF CEMETERY OR CREMATORY: Marietta National Cemetery	23d LOCATION (City or Town): Marietta, Georgia	(County) (State)
24 FUNERAL DIRECTOR: Arehart Funeral Home, LaPlata, Maryland — ADDRESS: Atlanta, Patterson F.H. Ga.		25a. REC'D BY REGISTRAR DATE: JUN 16 1967	25b. REGISTRAR'S SIGNATURE: J. Charles Judge	

VR A15 (4)
20 M 1/66

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08396

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08389

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 18 yr.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 4903 Edgemoore Lane

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland. b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 4903 Edgemoore Ln
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: James. Middle: Earl. Last: Hummer
4 DATE OF DEATH: Month: June. Day: 2. Year: 1967

5 SEX: M.
6 COLOR OR RACE: W.
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: Jan 16, 1900
9 AGE (In years last birthday): 67 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Carpenter.
10b KIND OF BUSINESS OR INDUSTRY: Transportation.
11 BIRTHPLACE (State or foreign country): Washington DC
12 CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Walter Hummer.
14. MOTHER'S MAIDEN NAME: Lula. —

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No.
16 SOCIAL SECURITY NO: 218-10-6064
17. INFORMANT: Wife. Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 3 Months.
4 or 1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Cardio Vascular Disease. —
DUE TO (c): —

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G. Ball M.D
EXAMINER'S NAME (Type): John G. Ball
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
22. DATE SIGNED: 6/2/67

23a BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b DATE THEREOF: 6/3/67
23c NAME OF ~~CEMETERY~~ OR CREMATORY: Ft. Lincoln
23d LOCATION (City or Town) (County) (State): Pr. Geo Co MD

24 FUNERAL DIRECTOR: W.W Chambers Co. ADDRESS: 1400 Chillum Rd Hyattsville
25a RECD BY REGISTRAR DATE: JUN 5 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (5)
6M 1/67

1

FOR STATE HEALTH DEPT.

M

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit if the pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08397

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08390

1 PLACE OF DEATH
a COUNTY: MONTGOMERY — MARYLAND
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): GAITHERSBURG
c LENGTH OF STAY IN 1b:
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): XXXX D.O.A. Montgomery Co., Gen. Hosp.

2 USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a STATE: MARYLAND — b COUNTY: MONTGOMERY
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GAITHERSBURG
d STREET ADDRESS: 7332 MUNCASTER MILL ROAD
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: HELENA — Middle: M. — Last: XXXXXXXXXX
4 DATE OF DEATH: Month: JUNE — Day: 19 — Year: 1967

5 SEX: FEMALE
6 COLOR OR RACE: WHITE
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: MAY 4, 1891
9 AGE (In years last birthday): 76 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEKEEPER
10b KIND OF BUSINESS OR INDUSTRY: Domestic
11 BIRTHPLACE (State or foreign country): West Virginia
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: John O. Humphreys
14 MOTHER'S MAIDEN NAME: Millie Ann Stone

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16 SOCIAL SECURITY NO.
17 INFORMANT — Address: MEDICAL RECORDS - MONTGOMERY GEN. HOSPITAL

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Acute Coronary Insufficiency — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Coronary, Artery, Heart Disease
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year — Hour o'm. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Belden R. Heap M.D.
EXAMINER'S NAME (Type): BELDEN R. HEAP M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, City, town or county)
22. DATE SIGNED: 6/19/1967

23a BURIAL CREMATION REMOVAL (Specify): Burial
23b DATE THEREOF: June 22nd, 67
23c NAME OF CEMETERY OR CREMATORY: St. Barnabas Cemetery
23d LOCATION (City or Town) (County) (State): Oxon Hill, Maryland

24 FUNERAL DIRECTOR: Simmons Bros.
ADDRESS: Simmons Bros. 1651- Good Hope RD. SE. Wash., DC
25a RECD BY REGISTRAR (DATE): JUN 21 1967
25b REGISTRAR'S SIGNATURE: J. Charles Yeager

VR A15ME (5)
6M 1/67

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08398

CERTIFICATE OF DEATH

08391

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 1900 Lyttonsville Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Dorothy — Middle: — Last: Hyman
4. DATE OF DEATH: Month: 6 — Day: 2 — Year: 19 67
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED
8. DATE OF BIRTH: 7/23/07
9. AGE (In years last birthday): 59 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Personnel Clerk
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Govt.
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? United States
13. FATHER'S NAME: MAX HECKLEMAN
14. MOTHER'S MAIDEN NAME: LENA ? ? ?
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 578-05-5588
17. INFORMANT: MRS MYRNA WRIGHT — Address: 2208 ELLIS ST SILVER SPRING, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Hepatic + Renal Insufficiency — Interval between onset and death: Days
DUE TO
(b): Generalized Carcinomatosis — 6 Months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO
(c): Adenocarcinoma of Sigmoid Colon — 6+ Months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (~~this hospital~~) attended the deceased from Feb., 1967, to June 2, 1967, that (I) (we) last saw the deceased alive on June 2 1967, and that death occurred at 5:05 P.M., from causes and on the date stated above.

22a. SIGNATURE: Gene U. Cohen MD — M.D — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: June 2, 1967
22c. PHYSICIAN'S NAME (Type): GENE U. COHEN, MD
22d. ADDRESS: 106 SPRING ST. SILVER SPRING MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 6-7-67
23c. NAME OF CEMETERY OR CREMATORY: WAR MEMORIAL PARK
23d. LOCATION (City or Town) (County) (State): FALLS CHURCH VA.

24. FUNERAL DIRECTOR: Goldberg Funeral Home — ADDRESS: 4217 9th St. NW
25a. REC'D BY REGISTRAR DATE: JUN 5 1967
25b. REGISTRAR'S SIGNATURE: [illegible] Judge

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08393 Item #8 Fi. #8390 6/23/67 pc 08392

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Washington — b. COUNTY: D.C.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
d. STREET ADDRESS: 453 Valley Ave. SE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Elizabeth — Middle: V. — Last: Jackson

4. DATE OF DEATH: Month: June — Day: 11 — Year: 1967

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS Hours / Min
F	NEGRO	7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	6/10/113	54 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY: (Country Club) Army-Navy-Club
11. BIRTHPLACE (County & State, or foreign country): Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME
14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Embolism — INTERVAL BETWEEN ONSET AND DEATH: Minutes
DUE TO (b): Adenocarcinoma of Breast — 20 yrs.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1 of X

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from [illegible], 1965, to 6/10, 1967, that (I) (~~we~~) last saw the deceased alive on 6/10 1967, and that death occurred at 1:20 A.M., from causes and on the date stated above.

22a. SIGNATURE: M. Leonard Gold M.D — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 6/11/67
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE THEREOF: 6-16-67
23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery
23d. LOCATION (City or Town) (County) (State): Washington, D.C.

24. FUNERAL DIRECTOR — ADDRESS: WASH. D.C.
John T. Rhines Funeral Home 3015 12 St. N. E.

25a. REC'D BY REGISTRAR DATE: JUN 15 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08400

CERTIFICATE OF DEATH

08393

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA (rural)
c. LENGTH OF STAY IN 1b: 5 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): NAVAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: PENNSYLVANIA
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): DANVILLE
d. STREET ADDRESS: BOX 192
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First RANDALL — Middle — Last JACOBS

4. DATE OF DEATH: Month JUNE — Day 19 — Year 19 67

5. SEX: MALE

6. COLOR OR RACE: CAUC

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 12 DECEMBER 1885

9. AGE (In years last birthday): 81 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): US NAVY

10b KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (County & State, or foreign country): DANVILLE, PENNSYLVANIA

12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: WILLIAM FREDERICK JACOBS

14. MOTHER'S MAIDEN NAME: JANE McCOY

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes give war or dates of service): 1903-1953

16 SOCIAL SECURITY NO: 172-30-6270

17. INFORMANT: MARY JANE JACOBS, 2416 42ND AVE, EAST SEATTLE, WASHINGTON

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Arteriosclerotic heart disease
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Carcinoma of bladder

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (X) (this hospital) attended the deceased from 14 JUNE, 1967, to 19 JUNE, 1967, that (I) (We) last saw the deceased alive on 19 JUNE 1967, and that death occurred at 1:15 AM, from causes and on the date stated above.

22a SIGNATURE: L.A. Jones, M.D. ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 19 June 1967

22c PHYSICIAN'S NAME (Type): L.A. JONES

22d. ADDRESS: NAVAL HOSPITAL, BETHESDA, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b DATE THEREOF: JUNE 21, 1967

23c. NAME OF CEMETERY OR CREMATORY: ARLINGTON NATIONAL

23d LOCATION (City or Town) (County) (State): ARLINGTON VA.

24 FUNERAL DIRECTOR: W.W. CHAMBERS, FUNERAL HOME, 1400 CHAPIN ST. N.W., WASHINGTON D.C.

25a. REC'D BY REGISTRAR DATE: JUN 21 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08401 — 08394

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 10200 Hatherleigh Road

2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 10200 Hatherleigh Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Edward — Middle: E. — Last: Jerome

4 DATE OF DEATH: Month: June — Day: 30, — Year: 19 67

5 SEX: Male

6 COLOR OR RACE: White

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 31 July 1917

9 AGE (In years last birthday): 49 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Communications Eng.

10b KIND OF BUSINESS OR INDUSTRY: Phone

11 BIRTHPLACE (County & State, or foreign country): Conn.

12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: Walter F. Jerome

14 MOTHER'S MAIDEN NAME: Kay Earl

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes, give war or dates of service): WW II

16 SOCIAL SECURITY NO: 042-07-2198

17. INFORMANT — Address: Evelyn A. Jerome-Item # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cerebrovascular Attack — INTERVAL BETWEEN ONSET AND DEATH: Minutes
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Acute Myocardial Infarction — 2 hrs.
DUE TO
(c): Arteriosclerotic Heart disease — 5 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan ____, 19 67 to June 30, 19 67 that (I) (we) last saw the deceased alive on July 15 19 67 and that death occurred at 10:50 A.M. from causes and on the date stated above

22a SIGNATURE: Wilfred R. Ehrmantrout, M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6/30/67

22c. PHYSICIAN'S NAME (Type): Wilfred R. Ehrmantrout

22d. ADDRESS: 11125 Rockville Pike, Rockville, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7/3/67

23c. NAME OF CEMETERY OR CREMATORY: Parklawn

23d LOCATION (City or Town) (County) (State): Rockville, Md.

24. FUNERAL DIRECTOR — ADDRESS: Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.

25a. REC'D BY REGISTRAR DATE: JUL 6 1967

25b. REGISTRAR'S SIGNATURE: [signature]

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08402 — Items #8 & 9 Film #6390 6/26/67 Pi — 08395

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Montgomery — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Carroll Hall Sanitarium

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Md. — b. COUNTY: Montgomery
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
   d. STREET ADDRESS: 9903 Dallas Ave.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elizabeth — Middle: F. — Last: Johnson

4. DATE OF DEATH: Month: 6 — Day: 1 — Year: 1967

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 5-9-1887 / 1885

9. AGE (In years last birthday): 82/81 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Berkelbach

14. MOTHER'S MAIDEN NAME: Caroline Fowler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Edith Richey — Address: Washington, D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generalized arteriosclerosis, especially cerebral — INTERVAL BETWEEN ONSET AND DEATH: 2 months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):
334X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Acute cystitis, severe

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from August, 1966, to June 1, 1967, that (I) (we) last saw the deceased alive on May 31 1967, and that death occurred at 1:00 PM, from the causes and on the date stated above.

22a. SIGNATURE: Bennet A. Porter, Jr MD — M.O. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: June 1, 1967

22c. PHYSICIAN'S NAME (Type): Bennet A. Porter, Jr MD

22d. ADDRESS: 9301 Colesville Rd., Silver Spring Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6-3-67

23c. NAME OF CEMETERY OR CREMATORY: Geo. Washington Cem.

23d. LOCATION (City, town or county) (State): Hyattsville, Md.

24. FUNERAL DIRECTOR: Lee Funeral Home — ADDRESS: Washington, D.C.

25a. REC'D BY REGISTRAR DATE: JUN 6 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20M 1/65

Johnson, Mrs. Elizabeth

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08403 — 08396

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Bethesda-Silver Spring Nursing Home

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Wash. D.C. — b. COUNTY: —
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 3929 Conn. Ave N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Gladys — Middle: Noble — Last: Johnson

4. DATE OF DEATH: Month: June — Day: 1 — Year: 19 67

5 SEX: Female

6 COLOR OR RACE: white

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: July 29 1893

9 AGE (In years last birthday): 73 yrs

IF UNDER 1 YEAR: Months: 10 — Days: 3
IF UNDER 24 HRS: Hours: — Min.: —

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (County & State, or foreign country): Michigan

12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James E. Noble

14. MOTHER'S MAIDEN NAME: Frances E. Stewart

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NC
(If yes give war or dates of service): —

16 SOCIAL SECURITY NO:

17 INFORMANT (Sow): FRANK E JOHNSON JR. — Address: 3501-Conn. Ave. Wash. D.C.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction, acute
DUE TO (b): Arteriosclerotic heart disease with
DUE TO (c): old healed anterior wall infarction

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH: Sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o m. p m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from 1945, 19__ to June 1, 1967, that (I) ~~(we)~~ last saw the deceased alive on May 31 1967, and that death occurred at 11:00 A M, from causes and on the date stated above.

22a. SIGNATURE: Arnold McNutt — M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b DATE SIGNED: June 1, 1967

22c. PHYSICIAN'S NAME (Type): ARNOLD McNITT, M.D.

22d. ADDRESS: 1835 Eye St., N.W. DC.

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b DATE THEREOF: 6/3/1967

23c NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery

23d LOCATION (City or Town) (County) (State): Prince Georges, MD

24. FUNERAL DIRECTOR: HYSONG FUN. HOME — ADDRESS: 1300-N St. NW WASH. D.C.
PER. Thomas M. Hysong

25a RECD BY REGISTRAR DATE: JUN 5 1967

25b REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CORRECTED COPY FOLLOWING COMPLETED AUTOPSY REPORT

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

8404

CERTIFICATE OF DEATH

08397

1. **PLACE OF DEATH** — a. COUNTY: MONTGOMERY — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
   c. LENGTH OF STAY IN 1b: 9 days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Montgomery General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Montgomery
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
   d. STREET ADDRESS: 3010 Norbeck Road
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First: Mattie — Middle: Virginia — Last: Johnson

4. **DATE OF DEATH**: Month: June — Day: 20 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 2-23-87

9. AGE (In years last birthday): 80 yrs
   IF UNDER 1 YEAR — Months: — Days: — IF UNDER 24 HRS — Hours: — Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Charles Johnson

14. MOTHER'S MAIDEN NAME: Laurea Owens

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT — Address: Hospital Records — Olney, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): PULMONARY CONGESTION, TERM. — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): PULMONARY METASTASIS — 1 yr.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c): CARCINOMA, THYROID, FOLLICULAR — Yes.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): A.S.C.V.D. OLD INFARCT MYOCARDIUM

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 3 Mar, 1967 to 6/20, 1967, that (I) (we) last saw the deceased alive on 6/19 1967, and that death occurred at 6:20 A.M., from causes and on the date stated above.

22a. SIGNATURE: D. R. Lewis. M.D — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): Donald R. Lewis, M.D.

22d. ADDRESS: 700 Cloverly St., Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 6/23/67

23c. NAME OF CEMETERY OR CREMATORY: SANDY SPRING CEMETERY

23d. LOCATION (City or Town) (County) (State): SANDY SPRING, MONTG. MD.

24. FUNERAL DIRECTOR — ADDRESS: Robert L. Snowden, Rockville, Maryland

25a. REC'D BY REGISTRAR DATE: June 27, 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge per MS

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items #3 & 14 Fi[illegible] 7/27/67 pn

08405

CERTIFICATE OF DEATH

08398

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (rural) c. LENGTH OF STAY IN 1b: 4 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Naval Hospital	2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase d. STREET ADDRESS: 3705 Dunlop Street e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print): First: Mary May — Middle: Jacqueline — Last: JOHNSTON	4. DATE OF DEATH: Month: June — Day: 26 — Year: 19 67
5. SEX: Female	6. COLOR OR RACE: Cauc
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: March 10, 1915
9. AGE (In years last birthday): 52 yrs	IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	10b. KIND OF BUSINESS OR INDUSTRY: — — —
11. BIRTHPLACE (County & State, or foreign country): Massachusetts	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: William S. Clark	14. MOTHER'S MAIDEN NAME: Mary Hohr Hoar
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): — —	16. SOCIAL SECURITY NO: 023-10-9155
17. INFORMANT: Chevy Chase — Address: Md. Mr. Robert Johnston, 3705 Dunlop Street	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): SUPPURATIVE TRACHEOBRONCHITIS
DUE TO (b): RECURRENT EPIDERMOID CARCINOMA
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): OF PHARYNX ? INVASION OF CRANIUM

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I (this hospital) attended the deceased from June 22, 1967, to June 26, 19 67 that I (we) last saw the deceased alive on June 26 19 67, and that death occurred at 730A M, from causes and on the date stated above.

22a. SIGNATURE: Hugh O. de Fries M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: June 26, 1967

22c. PHYSICIAN'S NAME (Type): Hugh O. de Fries

22d. ADDRESS: Naval Hospital, Bethesda, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE THEREOF: 6-29-1967	23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cemetery	23d. LOCATION (City or Town) (County) (State): Silver Spring, Maryland
24. FUNERAL DIRECTOR: Joseph Gawler & Sons ADDRESS: 5130 Wisconsin Ave., N.W., Washington, D. C.		25a. REC'D BY REGISTRAR DATE: JUN 29 1967	25b. REGISTRAR'S SIGNATURE: [illegible] Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08406 — 08399

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 12510 Littleton St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Dong — Middle: Shee — Last: Jok

4. DATE OF DEATH: Month: June — Day: 18 — Year: 1967

5. SEX: F

6. COLOR OR RACE: Yellow

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 4-20-99

9. AGE (In years last birthday): 68 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (County & State, or foreign country): China

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Unk.

14. MOTHER'S MAIDEN NAME: Unk.

15. WAS DECEASED EVER IN U.S ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Gordon J. Tong — Same as #2 — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Diffuse peritonitis.
DUE TO (b): Perforated marginal ulcer. (gastric)
DUE TO (c):

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.

5401

INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 6, 1967, to June 18, 1967, that (I) (we) last saw the deceased alive on June 17 1967, and that death occurred at 0115 P.M., from the causes and on the date stated above.

22a. SIGNATURE: W. S. Malcolm M.D.
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6-18-67

22c. PHYSICIAN'S NAME (Type):

22d. ADDRESS: 10620 Georgia Avenue Silver Spring Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6-20-67

23c. NAME OF CEMETERY OR CREMATORY: Geo. Wash. Memo. Cem.

23d. LOCATION (City, town or county) (State): Hyattsville, Md.

24. FUNERAL DIRECTOR — ADDRESS: Lee Funeral Home 300 4th St. NE Wash. D.C.

25a. REC'D BY REGISTRAR DATE: JUN 21 1967

25b. REGISTRAR'S SIGNATURE:

VR A15 (4)
20M 1/65

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of body; in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #2a,b,c & d Film #300 6023 pc

08407 **CERTIFICATE OF DEATH** 08408

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Potomac Valley N.H.

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
STATE: Maryland Va. — COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville Lynchburg
d. STREET ADDRESS: Potomac Valley N.H.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Franklin — Middle: — Last: Jones
4. DATE OF DEATH: Month: 6 — Day: 8 — Year: 19 67
5. SEX: Male
6. COLOR OR RACE: Colored
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: ?
9. AGE (In years last birthday): 65 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): ?
12. CITIZEN OF WHAT COUNTRY: U.S.
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): ?
16. SOCIAL SECURITY NO.: 579-14-1049
17. INFORMANT: Hosp. Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): cerebral infarction — INTERVAL BETWEEN ONSET AND DEATH: 5 hrs
DUE TO (b): Cerebral thrombosis — 4 hrs
DUE TO (c): cerebral arteriosclerosis — Indef
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Bronchitis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o m. p m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5/27/, 19 67, to 6/8/, 19 67, that (I) (we) last saw the deceased alive on 6/7/ 19 67, and that death occurred at 5:35 PM, from causes and on the date stated above

22a. SIGNATURE: Stephen N. Jones M.D — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 6/8/67
22c. PHYSICIAN'S NAME (Type): Stephen N. Jones
22d. ADDRESS: Rockville, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6-13-67
23c. NAME OF CEMETERY OR CREMATORY: Potters Field
23d. LOCATION (City or Town) (County) (State): Rockville, Md.

24. FUNERAL DIRECTOR: Tyson Wheeler — ADDRESS: 1331 Rockville Pike, Rockville, Md.
25b. REC'D BY REGISTRAR DATE: JUN 15 1967
25c. REGISTRAR'S SIGNATURE: Charles Jones

Item 21 Film 390 7-7-67 ams

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08408 Item #1c Film #G320 7/5/67 ps

CERTIFICATE OF DEATH

08401

1 M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25M 1/67

1 PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda c. LENGTH OF STAY IN 1b: 8 30/days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda, Md. 20014	2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE: Virginia — b. COUNTY: -- c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Alexandria d. STREET ADDRESS: 5825 Colfax Avenue e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3 NAME OF DECEASED (Type or print): First Mildred — Middle Elizabeth (Ives) — Last Kearney 5 SEX: Female 6. COLOR OR RACE: White 7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8 DATE OF BIRTH: May 23, 1906 9 AGE (In years last birthday): 61 yrs 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Secretary 10b KIND OF BUSINESS OR INDUSTRY: Retired 11 BIRTHPLACE (County & State, or foreign country): Florida 12 CITIZEN OF WHAT COUNTRY? USA 13 FATHER'S NAME: Washington Ives 14. MOTHER'S MAIDEN NAME: Mary Virginia Davis 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service) 16. SOCIAL SECURITY NO.: Not available 17. INFORMANT Address: The Medical Records, The Clinical Center, Bethesda, Md. 20014	4 DATE OF DEATH: Month June — Day 22 — Year 19 67 IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS: Hours / Min
MEDICAL CERTIFICATION 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Subarachnoid Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 days DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b): Acute tubular necrosis — 7 days DUE TO (c): Acute Myelogenous Leukemia — 3 weeks PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pneumonia 19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐ 20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.) 20f (City or town) (County) (State) 21. I certify that ☒ (this hospital) attended the deceased from May 23 June 1, 19 67, to June 22, 1967, that ☒ (we) last saw the deceased alive on June 22 19 67, and that death occurred at 9:05 AM, from causes and on the date stated above 22a. SIGNATURE Dr. Charles L Vogel M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS ☒ 22b. DATE SIGNED 22 June 1967 22c. PHYSICIAN'S NAME (Type) Charles L. Vogel, MD 22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify): Burial 23b. DATE THEREOF: 6/24/67 23c NAME OF CEMETERY OR CREMATORY: Ivy Hill Cemetery 23d. LOCATION (City or Town) (County) (State): Alexandria, Virginia 24. FUNERAL DIRECTOR: Wm. A. Mann ADDRESS: 3901 No. Fairfax Dr. Arlington, Virginia 22203 25a. REC'D BY REGISTRAR DATE: JUN 26 1967 25b REGISTRAR'S SIGNATURE: Charles Judge	

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08403 **CERTIFICATE OF DEATH** 08402

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page ... be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and not later than 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN: 3 weeks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 10312 Geranium Avenue

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Virginia
b. COUNTY: Alexandria
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Alexandria
d. STREET ADDRESS: 6122 Yellowstone Drive
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frances; Middle: O.; Last: Keesling

4. DATE OF DEATH: Month: June; Day: 5; Year: 19 67

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 5, 1904

9. AGE (In years last birthday): 62 yrs. IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (County & State, or foreign country): Kansas

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Clem Sweem

14. MOTHER'S MAIDEN NAME: Myrtle O. Strander

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No — None

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Hugh Keesling — Address: 8208 Jeb Stewart Road, Rockville, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 4 days

DUE TO (b): Malnutrition — 6 mos.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Metastatic Carcinoma of the stomach — 1 yr.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from May 19 67 to June 5, 19 67, that (I) (we) last saw the deceased alive on June 5 19 67, and that death occured at 4:55 P.M. from the causes and on the date stated above.

22a. SIGNATURE: William F. Morrissey M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6/6/67

22c. PHYSICIAN'S NAME (Type): William F. Morrissey

22d. ADDRESS: Arlington Virginia

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: June 8, 1967

23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery

23d. LOCATION (City, town or county) (State): Prince Georges Co., Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Glen Carter for Glen Carter

ADDRESS: 8434 Georgia Avenue, Silver Spring, Md.

Warner E. Pumphrey, Inc.

25a. REC'D BY REGISTRAR DATE: JUN 9 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08410 — 08403

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b: TWENTY YEARS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Home; 9300 PINEY BRANCH Rd. APT 303

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
d. STREET ADDRESS: 9300 PINEY BRANCH RD APT 303
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARIE — Middle LOUISE — Last KELLEY

4. DATE OF DEATH: Month JUNE — Day 12 — Year 1967

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JAN. 13, 1914

9. AGE (In years last birthday): 53 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BUDGET TECHNICIAN

10b. KIND OF BUSINESS OR INDUSTRY: U S GOVT

11. BIRTHPLACE (County & State, or foreign country): WASHINGTON DC.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOHN FITZGERALD

14. MOTHER'S MAIDEN NAME: Katherine Juenemann — KATHERINE JUENEMANN

15. WAS DECEASED EVER IN U S. ARMED FORCES? (Yes, no, or unknown) (If yes give wer or dates of service): NO

16. SOCIAL SECURITY NO.: 218-303-181

17. INFORMANT: HUSBAND — Address: JOHN KELLY SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute myocardial infarction
DUE TO (b): Arteriosclerotic Cardiovascular Disease
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Minutes — Approx 10 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 1) Diabetis Mellitus 2) Pulmonary Emphysema

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) — (County) — (State)

21. **I certify** that (I) ~~(this hospital)~~ attended the deceased from approx. 1962 to June 12, 1967, that (I) (~~was~~) last saw the deceased alive on May 22 1967, and that death occured at BEFORE 8 AM M, from the causes and on the date stated above.

22a. SIGNATURE: Gene U. Cohen, M.D.

22b. DATE SIGNED: 6-12-67

22c. PHYSICIAN'S NAME (Type): GENE U. COHEN, M.D.

M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22d. ADDRESS: 1106 SPRING ST SILVER SPRING, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6-15-67

23c. NAME OF CEMETERY OR CREMATORY: St. John's Cemetery

23d. LOCATION (City, town or county) — (State): Forest Glen, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: F. J. Collins

ADDRESS: Wash. D.C.

Francis J. Collins 3821 14th. St. N.W.

25a. REC'D BY REGISTRAR DATE: JUN 14 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08411

CERTIFICATE OF DEATH

08404

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c LENGTH OF STAY IN 1b: 13 days
d NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): The Clinical Center, Bethesda, Maryland

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Virginia — b. COUNTY: Fairfax
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Vienna
d STREET ADDRESS: 2423 Holt Street
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Ruth — Middle: Ann — Last: Kelliher
4. DATE OF DEATH: Month: June — Day: 27 — Year: 19 67

5 SEX: Female
6 COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 29 July 1962
9 AGE (In years last birthday): 4 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child
10b. KIND OF BUSINESS OR INDUSTRY: ---
11. BIRTHPLACE (County & State, or foreign country): Connecticut
12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: Daniel W. Kelliher
14. MOTHER'S MAIDEN NAME: Marlene Bickert

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): ---
16 SOCIAL SECURITY NO: None
17. INFORMANT: The Medical Records — Address: The Clinical Center, Bethesda, Maryland 20014

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Septicemia — INTERVAL BETWEEN ONSET AND DEATH: 48 Hours
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 3043
(b): Acute Lymphocytic Leukemia — 2 Weeks
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from June 14, 19 67, to June 27, 1967, that ☒ (we) last saw the deceased alive on June 27 19 67, and that death occurred at 2:15 AM, from causes and on the date stated above.

22a. SIGNATURE: Joel J Rubenstein — M.D. ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS ☒
22b DATE SIGNED: 27 June 1967
22c PHYSICIAN'S NAME (Type): Joel J. Rubenstein, MD.
22d ADDRESS: The Clinical Center, National Institutes of Health, Bethesda, Md. 20014

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 6-30-67
23c NAME OF CEMETERY OR CREMATORY: Clarence Fillmore
23d LOCATION (City or Town) (County) (State): Clarence, New York (Erie Co.)

24 FUNERAL DIRECTOR: Money & King — ADDRESS: 171 W. Maple Ave. Vienna, Va.
25a RECD BY REGISTRAR DATE: JUN 30 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A111 (4)
25M 1/67

Hrlo

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08412

CERTIFICATE OF DEATH

08405

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): KENSINGTON
c. LENGTH OF STAY IN 1b: 4 YEARS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 4301 Dunnell Lane

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) — a. STATE: MARYLAND — b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): KENSINGTON.
d. STREET ADDRESS: 4301 DUNNELL LANE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: WILLIAM — Middle: JOSEPH — Last: KRIZ
4. DATE OF DEATH: Month: JUNE — Day: 1 — Year: 1967

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JANUARY 16, 1907
9. AGE (In years last birthday): 60 yrs. — IF UNDER 1 YEAR: Months 4, Days — IF UNDER 24 HRS.: Hours, Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RADIO ENGINEERS WTOP
10b. KIND OF BUSINESS OR INDUSTRY: — —
11. BIRTHPLACE (County & State or foreign country): BALTIMORE, MD.
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: JOSEPH KRIZ
14. MOTHER'S MAIDEN NAME: MARIE MASINDA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes give war or dates of service): — — —
16. SOCIAL SECURITY NO.: 577-09-8924
17. INFORMANT: Mrs. Edna Kriz — Address: 4301 Dunnell Land Kensington MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): CARCINOMA OF THE PROSTATE. — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): WITH METAS TASES. — OVER 6 YEARS
DUE TO
(c):

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

(June 1, 1967)

21. I certify that (I) (this hospital) attended the deceased from August, 1961, to May 30, 1967, that (I) (we) last saw the deceased alive on May 30, 1967, and that death occurred at 12:30 PM, from causes and on the date stated above

22a. SIGNATURE: Hugo G. Graziani, MD. for Ob. Sarah Kimble — M.D. — ATTENDING PHYS ☒ — MED DIRECTOR ☐ — STAFF PHYS. ☐
22b. DATE SIGNED: 6/1/67
22c. PHYSICIAN'S NAME (Type): HUGO G. GRAZIANI, M.D.
22d. ADDRESS: 10101 GEORGIA AVE, SILVER SP. MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: 6-3-1967
23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
23d. LOCATION (City or Town) (County) (State): Prince Georges Co. Md.

24. FUNERAL DIRECTOR — ADDRESS: Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W. Wash. DC.
25a. RECD BY REGISTRAR DATE: JUN 7 1967
25b. REGISTRAR'S SIGNATURE: [illegible]

VR A15 (4) 25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08413

CERTIFICATE OF DEATH

Item #2c & d [illegible]

08406

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b: 3 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Potomac Valley Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Rockville~~ Bethesda, Md. 20014
d. STREET ADDRESS: 9205 Adelaide Court
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒
Potomac Valley Nursing Home

3. NAME OF DECEASED (Type or print): First: EDNA; Middle: ; Last: LAMPE

4. DATE OF DEATH: Month: June; Day: 8; Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** XX **DIVORCED** ☐

8. DATE OF BIRTH: Mar 1 1896

9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): New Jersey

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Ashmore

14. MOTHER'S MAIDEN NAME: Charlotte Love

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): NO.

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Dorothy L. Flynn (Daughter) Address: 9205 Adelaide Ct. Beth. Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Terminal Pneumonia

DUE TO (b): Generalized Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 4 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)**

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ..... 19..., to 8 June 19 67, that (I) (we) last saw the deceased alive on 5 June 19 67, and that death occured at 9:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Jere S. Daum M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8 June 67

22c. PHYSICIAN'S NAME (Type): JERE S. DAUM

22d. ADDRESS: 4977 Battery Lane Bethesda Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6/10/67

23c. NAME OF CEMETERY OR CREMATORY: Cloverleaf Cemetery

23d. LOCATION (City, town or county): Woodbridge N.J. (State)

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. DeSoe

ADDRESS: Washington D.C.

25a. RECD BY REGISTRAR DATE: JUN 14 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page [redacted] may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page [redacted] should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08414 — 08409

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wheaton.
c. LENGTH OF STAY IN 1b: 7days.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Randolph Hills Nursing Home.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland. b. COUNTY: Montgomery.
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 10019 Lorain Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Grace. Middle: None. Last: London
4. DATE OF DEATH: Month: June. Day: 10. Year: 1967

5. SEX: Fe.
6. COLOR OR RACE: W.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Sept. 19, 1879
9. AGE (In years last birthday): 87 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Julian Hammersloogh.
14. MOTHER'S MAIDEN NAME: Cecilia. Meyers.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO: 215-01-6276D
17. INFORMANT: Son. Harvey L. Landin. Address: 5006 Elmer Ave. Baltimore. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Congestive Heart Failure. — INTERVAL BETWEEN ONSET AND DEATH: 6 wks.
DUE TO (b): Arterio Sclerosis generalized — Years.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fracture of Left Hip.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20c. EXTERNAL CAUSE WAS [redacted] or CONTRIBUTING CAUSE OF DEATH: Contributing!
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18): Fell in street when shopping
20c. TIME OF INJURY Month, Day, Year: 7:30 Hour pm April 01 1967
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Street.
20f. (City or town) (County) (State): Silver Spring Mont. Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G. Ball M.D.
EXAMINER'S NAME (Type): John G. Ball
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22. DATE SIGNED: 6/10/67
Address (Street, city, town, or county): 7936 Georgetown Rd. Bethesda. Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6/13/67
23c. NAME OF CEMETERY OR CREMATORY: Druid Ridge
23d. LOCATION (City or Town) (County) (State): Pikesville Balto. Md.

24. FUNERAL DIRECTOR: Loring Byers Randallstown Md. 21133
ADDRESS: Wallace W. Boyd

25a. RECD BY REGISTRAR DATE: JUN 15 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

38413 08410

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 17 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda R.F.D.
d. STREET ADDRESS: 4502 Maple Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First David Middle Laughlin Last
4. DATE OF DEATH: Month 6 Day 20 Year 19 67

5. SEX: M
6. COLOR OR RACE: W.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11-3-89
9. AGE (In years last birthday): 77 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Real Estate
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Bedford Va.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Laughlin
14. MOTHER'S MAIDEN NAME: Martha Flynn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service): No.
SOCIAL SECURITY NO: 578-03-7643
17. INFORMANT: Dorothy McCuliffe Address 4618 Rosedale Ave. Bethesda

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cerebral Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 4 hours
DUE TO (b): Hypertension Arteriosclerotic — 3 years
DUE TO (c): Cerebral-Cardio-Vascular Renal Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 331X

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Uremia
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from June 7, 1967, to June 20 1967, that (I) (we) last saw the deceased alive on 7-20 1967, and that death occurred at 6:15 PM from causes and on the date stated above

22a. SIGNATURE: P.P. Andrews M.D.
ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 6-20-67
22c. PHYSICIAN'S NAME (Type): P. P. ANDREWS M.D.
22d. ADDRESS: WASHINGTON, D.C 20016

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6/23/67
23c. NAME OF CEMETERY OR CREMATORY: Parklawn
23d. LOCATION (City or Town) (County) (State): Rockville, Maryland

24. FUNERAL DIRECTOR ADDRESS: Tyson Wheeler Funeral Home-1391 Rockville Pike Rockville, Md.
25a. REC'D BY REGISTRAR DATE: JUN 23 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items #2c, 17 & 21 from #08420 & 08417 pc

08416

CERTIFICATE OF DEATH

08411

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c LENGTH OF STAY IN 1b: 31 days
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: D.C. — b COUNTY: —
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington Springfield
d STREET ADDRESS: 5805 Ridgefield Road
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Carrie — Middle: B. — Last: Leach
DATE OF DEATH: Month: June — Day: 21 — Year: 1967

4 SEX: F.
5 COLOR OR RACE: W
6 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
7 DATE OF BIRTH: 8/6/80
8 AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b KIND OF BUSINESS OR INDUSTRY: —
11 BIRTHPLACE (County & State, or foreign country): Westmoreland Co. VA
12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Reed
14. MOTHER'S MAIDEN NAME: Florence Baker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No.
16. SOCIAL SECURITY NO: 579-60-1885
17 INFORMANT: Carolyn [redacted] Address: Same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Cerebral Vas. C. Accident — INTERVAL BETWEEN ONSET AND DEATH: 1 mo
DUE TO (b): Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): —

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5-22-, 1967, to 6-21-, 1967 that (I) ~~(we)~~ last saw the deceased alive on 6/21 1967, and that death occurred at 7:30 PM, from causes and on the date stated above.

22a SIGNATURE: W. Fleet Luckett, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 6-21-67
22c. PHYSICIAN'S NAME (Type): Dr. Wm. F. Luckett
22d. ADDRESS: 5000 Reno Road, N.W. Wash. DC.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6-24-1967
23c NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
23d LOCATION (City or Town) (County) (State): Suitland, Md.

24. FUNERAL DIRECTOR: Joseph Gawler's Son — ADDRESS: Washington D.C.
25a RECD BY REGISTRAR DATE: JUN 26 1967
25b REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08417

CERTIFICATE OF DEATH

08412

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 7 days.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Wash. San. & Hosp

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wheaton
d. STREET ADDRESS: 12807 Flack St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Dorothy Middle: Marie Last: Leahy

4. DATE OF DEATH: Month: 6 Day: 8 Year: 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2/1/1912
9. AGE (In years last birthday): 55 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Hswf.
10b. KIND OF BUSINESS OR INDUSTRY: Home-Maker
11. BIRTHPLACE (County & State or foreign country): [redacted] Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Victor Laciney
14. MOTHER'S MAIDEN NAME: Marie Grimm-

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Hosp. Record — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
(b): Congestive Heart Failure — 3dys
DUE TO
(c): Cirrhosis of the liver — 2yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6-1, 1967, to 6-8, 1967, that (I) (we) last saw the deceased alive on 6-8 1967, and that death occurred at 5:50 PM, from causes and on the date stated above.

22a. SIGNATURE: R. H. Sandstrom — M.D. ATTENDING PHYS ☑ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 6-9-67
22c. PHYSICIAN'S NAME (Type): R. H. Sandstrom
22d. ADDRESS: 7707 Carroll Ave Takoma Park, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 6/12/1967
23c. NAME OF CEMETERY OR CREMATORY: FORT LINCOLN CEMETERY
23d. LOCATION (City or Town) (County) (State): PRINCE GEORGES COUNTY, MD.

24. FUNERAL DIRECTOR: HYSONG'S FUNERAL HOME — ADDRESS: 1300-N. STREET, N.W. WASH. D.C.
25a. REC'D BY REGISTRAR DATE: JUN 12 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4) 25M 1/67

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08418 — 08407

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WHEATON
c. LENGTH OF STAY IN 1b: 1 YEAR + 6 mo

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
d. STREET ADDRESS: 9802 LORAIN AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): UNIVERSITY NURSING HOME

3. NAME OF DECEASED (Type or print): First HARRY — Middle HOBURG — Last LEE

4. DATE OF DEATH: Month JUNE — Day 28 — Year 1967

5. SEX: M

6. COLOR OR RACE: CAUC

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 5-21-1892

9. AGE (In years last birthday): 75 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Redeemed Currency Section

10b. KIND OF BUSINESS OR INDUSTRY: Treasury Dept.

11. BIRTHPLACE (County & State, or foreign country): EASTON - MD

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: WILLIAM THOMAS LEE

14. MOTHER'S MAIDEN NAME: EMMA OREGON ROBERTS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): June

16. SOCIAL SECURITY NO.: 213-50-1047

17. INFORMANT: Hoburg Lee — Address: 6305 Landon Lane Bethesda, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4-5 days
DUE TO (b): arteriosclerosis — ?
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I **certify** that (I) (this hospital) attended the deceased from _____, 19 54, to 27 June, 19 67, that (I) (we) last saw the deceased alive on 27 June 19 67, and that death occurred at 0 3:30 PM, from causes and on the date stated above.

22a. SIGNATURE: William D. And — M.D. ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 6/28/67

22c. PHYSICIAN'S NAME (Type): William D. And

22d. ADDRESS: 9006 Colesville Rd., Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: July 1, 1967

23c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery

23d. LOCATION (City or Town) (County) (State): Rockville, Maryland

24. FUNERAL DIRECTOR: John K. Thomas — ADDRESS: 8434 Georgia Avenue — Warner E. Pumphrey, Inc. Silver Spring, Maryland

25a. REC'D BY REGISTRAR — DATE: JUL 5 1967

25b. REGISTRAR'S SIGNATURE

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08413 08413

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Montgomery — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): #6 Hesketh Street,

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: D.C. — b. COUNTY: — — —
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
   d. STREET ADDRESS: 3139 19th Street, N.W.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bertram — Middle: Gorman — Last: Lennon

4. DATE OF DEATH: Month: JUNE — Day: 13 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1-10-1893

9. AGE (In years last birthday): 74 yrs.
   IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Insurance

10b. KIND OF BUSINESS OR INDUSTRY: Real Estate

11. BIRTHPLACE (County & State, or foreign country): Ireland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James F. Lennon

14. MOTHER'S MAIDEN NAME: — — Gorman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No — — — —

16. SOCIAL SECURITY NO.: 578-54-2886

17. INFORMANT: Mrs. Patricia Lennon Richards — Address: 8611 Burning Tree Road, Bethesda, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma ileocecal region with pulmonary metastases — INTERVAL BETWEEN ONSET AND DEATH: 14 months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from May 23, 1967 to June 13, 1967, that (I) (~~we~~) last saw the deceased alive on June 13, 1967, and that death occurred at 8:07 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Robert N. Coale — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: June 13, 1967

22c. PHYSICIAN'S NAME (Type): ROBERT N. COALE — 22d. ADDRESS: 4429 Bradley Lane, Chevy Chase, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 6-17-1967 — 23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery — 23d. LOCATION (City, town or county) (State): Washington, D.C.

24. FUNERAL DIRECTOR: Joseph Gawler's Sons, Inc. — ADDRESS: 3130 Wisc. Ave. Wash. D.C.

25a. REC'D BY REGISTRAR DATE: JUN 19 1967 — 25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

4-1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08420

CERTIFICATE OF DEATH

08414

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 105 Hodges Lane

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takima Park
d. STREET ADDRESS: 105 Hodges Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MABEL Middle HEWLETT Last LEWIS

4. DATE OF DEATH: Month June Day 1 Year 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Feb. 10, 1884

9. AGE (In years last birthday): 83 yrs.

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (County & State or foreign country): Wilmington, North Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ephriam Newlett

14. MOTHER'S MAIDEN NAME: Fannie Potter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 240-10-4561

17. INFORMANT: Mrs. Leary L. Waters (same as #2) — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 10 min.

4 or 1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Coronary Heart Disease — 5 years

DUE TO (c): Arteriosclerosis — 10 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1950, 19__, to 6/1/67, 19__, that (I) (we) last saw the deceased alive on 1 May 1967, and that death occurred at 2:45 P.M., from the causes and on the date stated above.

22a. SIGNATURE: M F Queen M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 6/1/67

22c. PHYSICIAN'S NAME (Type): M B. QUEEN

22d. ADDRESS: 344 University Blvd. W Silver Spring Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: June 3, 1967

23c. NAME OF CEMETERY OR CREMATORY: Winter Park Cemetery

23d. LOCATION (City, town or county) (State): Winter Park, North Carolina

24. FUNERAL DIRECTOR: J. Arthur Walters — ADDRESS: 254 Carroll St Silver Spring Md

25a. REC'D BY REGISTRAR DATE: JUN 5 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08421 — 08408

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL Bethesda
c. LENGTH OF STAY IN 1b: 9 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Naval Hospital, Bethesda, Md.

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Florida — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hollywood
d. STREET ADDRESS: 6851 N.W. 19th Court
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: William — Middle: C. — Last: LINDSEY

4. DATE OF DEATH: Month: Jun — Day: 30 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: Cauc

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11-10-1898

9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S. Navy (retired)

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Ashville, N.C.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Thomas LINDSEY

14. MOTHER'S MAIDEN NAME: Elizabeth (unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): yes / unknown

16. SOCIAL SECURITY NO: unknown

17. INFORMANT: Frances LINDSEY — Address: 6851 N.W. 19th Court, Hollywood, Florida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Carcinoma of the Esophagus — INTERVAL BETWEEN ONSET AND DEATH
100X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that ~~I~~ (this hospital) attended the deceased from 21 Jun, 1967, to 30 Jun, 1967, that ~~I~~ (we) last saw the deceased alive on 30 Jun 1967, and that death occurred at 1020P M, from causes and on the date stated above.

22a. SIGNATURE: B. M. Onofrio Lcdr MC USN — ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS. ☒ M.D.
22b. DATE SIGNED: 2 Jul 1967
22c. PHYSICIAN'S NAME (Type): B. M. ONOFRIO
22d. ADDRESS: Naval Hospital, Bethesda, Md.

23a. ~~BURIAL~~, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: 7/5/67
23c. NAME OF ~~CEMETERY~~ OR CREMATORY: Grove Park
23d. LOCATION (City or Town) (County) (State): Miami Fla.

24. FUNERAL DIRECTOR: W..W. CHAMBERS — ADDRESS: 1400 Chapin St., N.W. Washington, D.C.
25b. RECD BY REGISTRAR DATE: JUL 6 1967
25c. REGISTRAR'S SIGNATURE: [signature]

VR A15 (4)
25M 1/67

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08422

CERTIFICATE OF DEATH

08415

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours of death.

1. **PLACE OF DEATH** — a. COUNTY: Montgomery — MARYLAND; b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda; c. LENGTH OF STAY IN 1b: 69 days; d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda, MD.20014

2. **USUAL RESIDENCE** (Where deceased lived, if institution, Residence before admission) — a. STATE: Messenia, Greece; b. COUNTY; c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Filiatra 15.1; d. STREET ADDRESS: (No street address); e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. **NAME OF DECEASED** (Type or print): First: Stavros; Middle: (None); Last: Litsas

4. **DATE OF DEATH**: Month: June; Day: 22,; Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 17 March 1937

9. AGE (In years last birthday): 30 yrs

IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Agriculture

11. BIRTHPLACE (County & State, or foreign country): Greece

12. CITIZEN OF WHAT COUNTRY? Greece

13. FATHER'S NAME: Basil Litsas

14. MOTHER'S MAIDEN NAME: Toyla Katsoyli

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No —

16. SOCIAL SECURITY NO: None

17. INFORMANT: The Medical Records — Address: The Clinical Center, Bethesda, Maryland 20014

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cardiac-Respiratory Failure — INTERVAL BETWEEN ONSET AND DEATH: 3 hours

DUE TO (b): Septicemia — 7 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Renal Failure — 30 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Complete Correction, Tetralogy of Fallot

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour, a.m. p.m., 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that [X] (this hospital) attended the deceased from April 14, 1967, to June 22, 1967, that [X] (we) last saw the deceased alive on June 22, 19 67, and that death occurred at 7:22 PM, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS [ ] MED DIRECTOR [ ] STAFF PHYS [X]

22b. DATE SIGNED: 24 June 1967

22c. PHYSICIAN'S NAME (Type): Sewell H. Dixon, Jr.

22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF: 6-27-67

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City or Town) (County) (State): Athens Greece

24. FUNERAL DIRECTOR — ADDRESS: Frazer's Funeral Home Inc. 38-R Dave, N.W. DC

25a. REC'D BY REGISTRAR DATE: JUN 28 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

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25M 1/67

Items 18-21 Film 390
7-13-67 ams

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08423 08416

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASHINGTON SAN. & HOSP.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
d. STREET ADDRESS: 7709 GARLAND AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN Middle DOUGLAS Last LIVINGSTON
4. DATE OF DEATH: Month JUNE Day 5 Year 1967
5. SEX: M
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6-10-94
9. AGE (In years last birthday): 72 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED TEACHER
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): KANSAS
12. CITIZEN OF WHAT COUNTRY? AMER.
13. FATHER'S NAME: LINDLY LIVINGSTON
14. MOTHER'S MAIDEN NAME: ROSS
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: MRS. MABLE LIVINGSTON - WIFE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple extreme internal injuries — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b): due to fall
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
902.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Deceased, pruning tree, fell 40 ft. to ground.
20c. TIME OF INJURY Month, Day, Year: 5 Hour a.m. 45 p.m. 6-5 1967
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Backyard
20f. (City or town) Takoma Park (County) Montg (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Belden R. Leap M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): BELDEN R. LEAP M.D.
Address (Street, city, town or county): Laytonsville
22. DATE SIGNED: June 6, 1967

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: June 8-1967
23c. NAME OF CEMETERY OR CREMATORY: Geo. Peck Cemetery
23d. LOCATION (City or Town): Riggs Rd & Geo. (County) (State) Md.
24. FUNERAL DIRECTOR: Arthur Walters
ADDRESS: 254 Carroll St. N.E.
25a. REC'D BY REGISTRAR DATE: JUN 9 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08424 08417

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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25M 1/67

PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 39 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, DC 20016
d. STREET ADDRESS: 5607 Parkston Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Minerva	M.	Luke	6	14	1967

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	☒ Married ☐ Never Married ☐ Widowed ☐ Divorced	9/23/88	68 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (County & State, or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: John Robarge
14. MOTHER'S MAIDEN NAME: Belinda Duane

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): — — —
16. SOCIAL SECURITY NO.: 578-62-4096
17. INFORMANT Address: Charles O. Luke - See Item No. 2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Melanoma — INTERVAL BETWEEN ONSET AND DEATH: 7 mos.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): — DUE TO
(c): —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) ~~(this hospital)~~ attended the deceased from Jan, 1967, to 6/14, 1967, that (I) ~~(we)~~ last saw the deceased alive on 6/13 1967, and that death occurred at 6:25 AM, from causes and on the date stated above.

22a. SIGNATURE: G Leonard Gold — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 6/14/67
22c. PHYSICIAN'S NAME (Type): Dr. G. Leonard Gold
22d. ADDRESS: 8641 Cloesville Rd. Silver Sp. Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Removal	6-17-1967	Pulaski Cemetery Assn.	Pulaski, N.Y.

24. FUNERAL DIRECTOR: Joseph Gawler's Sons, Inc. — ADDRESS: 5130 Wisc. Ave. N.W. Wash. D.C.
25a. REC'D BY REGISTRAR DATE: JUN 19 1967
25b. REGISTRAR'S SIGNATURE: J Charles Junge